07-02171 Lisa Wilson Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

isa Wilson Smith	1-	For State	St	ate of Mary	land / D	epartm Certific			Menta	al Hy	giene	Reg. No	. 20	07	10001
Physician/		egistrar Decedent's Name	(First, Midd	le,Last)			_			2	. Date of D	eath			3. Time of Death
Medical Examine		Lisa Wil									Month March 2	Day 20, 200	Year 7		2113 hrs
\$	4	a. Facility Name (if			number)		- 1	lb. City, Town, or L	ocation of	Death			4c. County o		
		Peninsula Re	egional M	ledical Center				Salisbury					Wicomic		
Funeral	5	. Social Security N	umber	6. Sex	7. Age (I	n yrs. last bir	thday)	If Under 1 Year Months Days	If Under Hours	24Hrs.	8. Date of	Birth(MI	M/DD/YYYY)	Foreign	place (State or Washington
Director		225-21-3	165	1 M 2 X F		43	Yrs		riouis		May 1	.0.	1963 _	Cou	ntry) DC
	-	sual Residence of												—-т	10d. Inside City Limits
w any	1		10b. County		10	c. City, Town									1 Yes 2 No
Varyland 28a-f show any d at once. rector	şL	MD		hester		C	ambr					140= 0	itizen of Wh	at Cauni	Λ
the Maryland a or 28a-f sh iffied at one Director	2   1	0e. Street and Num 312 Washi		Ctroot				10f. Zip Code	21613	כ		Tug. C			uy:
h the 23a or	Ī		LIIGLOII								- 6 . V	No	USA		an Indian, Black,
er death with to or items 23s r. must be not		Marital Status     Never Marrie	d 2 X м	1	ecedent Eve Forces?	er in U.S.		s Decedent of Hisp es, specify Cuban,				NO-	White		all Illuali, black,
or dea	3			1 Yes		No	1 🗆	Yes 2 X No	specify:				Specify: \	whit	e
aral".	∑ -	Widowed  15. Decedent's Edition		or Dates:		eted) 16a.	Deceder	t's Usual Occupati		ind of wo	ork done	16b	. Kind of Bu		
"nati	<u> </u>	Elementary/Secon			(1-4 or 5+)		during m	ost of working life.	DO NOT I	use retire	ed)				
hin 7. than than edical		12		5+	-		data	entry							
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	5 1	7. Father's Name (	First, Middle		_			1	8.Mother's	s Name (	First, Midd	le, Maide	en Surname)		
215 be file ntal H rked c		Raymond	E1woo	d Wilson		254					ne Ga		11700		
ould d Mer is mail	2 1	9a. Informant's Na	me/Relations	ship (Type, Print)		1.9		Address (Street							Zip Code)
MD d 2 sh lth an n 27 i		O.C.M.E.						enn Stre		alti:	more,	MD	2120 c. Location -		Town State
Fe, s l an f Hea		0a. Method of Disp		n 3 Removal	from State	1		sition (Name of cen her place)	netery,		Date	200	c. Location -	City of	Town, State
Page pent o		4 X Donation 5	_		,										
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	7	21. Signature of Fur Ro	neral ervice	Licensee S. Wad	Direc	ctor	22. N S t	Name and Address ate Anato	of Facility	oard	655	W. E	3altim	ore	Street
<b>0</b> 8 8 <b>1</b>		///	20	r complications tha	/// -	-	[Ba]	ltimore.	MD	2120	1				Approximate Interval
Physician /Medical	2	3a. Part Enter th	ë disëase, o y one cause	e on each line.					such as ca	ardiac oi	respiratory	allest, s	STOCK, OF TICE	411	Between Onset and Death
Examiner		Immediate douse (I		e a <u>Compli</u>	cations	s of neu	ırofib	romatosis						-	Beatt
and the same of th	- [	or condition resultin	ig in death)	Due to (or a	s a consequ	ence of):									
	5	Sequentially list cou f any, leading to im	nditions, imediate	Due to (or a	s a consequ	uence of):									
		cause. Enter Under (Disease or injury t	rlying Cause	c											
ted nisit	Xal	events resulting in	death) Last	Due to (or a	s a consequ	uence of):									
e be executed ysician and burial - transit	Ę  -	[ ]psupsp	<del></del>	d.				<u> </u>			-				
0, the execut sician and burial - tra		X UNPENDED		#23a	PII.2	7.perME	<u>e869</u>	7/26/07 T	T				23d. Date of	delivery	
Division of Vital Records, P.O. Box 68760 rate or Attending Physician: The law requires that the death certificate is after death.  "al Director: After this certificate has been signed by the attending physical by the flueral director, page 2 should be detached for use as the bear in by the flueral director, page 2 should be detached for use as the bear in by the flueral director.	Physician/w	F FEMALE: 3b. Was decedent		the	s, outcome e birth	of pregnancy		etal death 3	Ectopic	pregnar	псу	- 1	Month		ay Year
K 68	2	past 12 months		4 Pre				ther (Specify)							
Bo) e death the att	S	1 Yes 2 1		3 011	known							$\perp$			ul a se de ade O
ords, P.O. B w requires that the de s been signed by the should be detached i		Part II. Other signi	ficant cond	itions contributin	g to death b	ut not resulti	ng in the	underlying cause (	given in Pa	art I.	23e. E	id tobac Yes 2			the cause of death?  pably 4  Unknown
ires th	o o	Comp1:	ication:	s of uterin	<u>e leio</u>	nyomata							2500000	- 152	topsy findings available
cords law requi has been 2 should	<u> </u>							_			a	Vas an autopsy		prior to c	completion of cause of
Reco The law icate has	Completed		_									erformed		death? ✔ Ye	es 2 No
tal Rection: The certificate	ပ္ပုံ-	25. Was case refer	red to medic	al				26.Place	of Death	(Check o	only one)				
Vital I hysician: this certifi	Ď	examiner?	2 No	Hospital: 1	Inpatient	2 ER/	Outpatier	t 3 DOA	Other <sub>4</sub>	Nursin	g Home 5	Res	sidence 6	Other	r.
ion of \\ Itending Phy leath.  tor: After the funeral	-1	27. Manner of Dea		28a. D	ate of Injury		. Time of		ry at Work	.	28d. Desc	ribe how	injury occur	red	
on endir sath. or: A	흵	1 X Natural		nding restigation	,			1	Yes 2	No					
ivisior  I or Attend after death Director:	≌	2 Accident 3 Suicide		uld not be 28e. F	lace of Inju	ry - At home,	farm, stre	eet, factory, office b	ouilding, et	tc.		ion (Strewn, State		er or Ru	ural Route Number, City
Divi	Certification:	4 Homicide	det	termined (Spec											
Hospital 24 hours Funeral		29a. Certifier 1	Certifying	Physician: To the	best of my	knowledge, d	eath occi	urred at the time, d	ate and pla	ace, and	due to the	cause(s	) and manne	r as stat	ed.
Division of Vital Records, P.O. Box  To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attended to the property filled in by the funeral director, page 2 should be detached for understanding the property of the p	Medical	one) 2 🗸	1	caminer: On the ba	sis of exami er stated.	nation and/o	r investig			curred a	it trie time,				
	ž	29b. Signature and	title of certi		/ /			29c. Licens					_		nth, Day, Year)
No m		The +	du	11.10	74/5	Ru AL	un	O.C.	M.E.			^	/larch 21,	2007	
38 Cang	1	30 Name and add	ress of perso									1001			17.
0 4		Theodore N	/I. King, J			dical Exa	miner	111 Penn St	reet, Ba	altimore	e, MD 2	1201			
Sta	100	31. Date filed (Mor		·	. Registrar's	s Signature	A	ands!							
Registr	ar		MAR 2	9 2007	1.1809.0	E. S. fills	-								

			For State	State of	Maryland		rtment of			lental Hy	giene		10000
		ē.	Registrar  1. Decedent's Name (First, Middle	e Last)		Cer	tificate of	Deam		2. Date of De	Reg. No	2007	3. Time of Death
	Physicia		Benedict F.							Month March	Day	2007 Year	7:29 AM M
-	/Medic Examin		4a. Facility Name (If not institution		ber)		4b. City, Town,	or Location	of Death	1101011		County of Death	1.025
			Southern Mai	ryland Hosp	pital		Clinto				P	rince Ge	orge's
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bir (Month, Da	ay, Year)	Coui	
,X	Director		216-22-3466 Usual Residence of Decedent	H	78	115.				Feb 3,	1929	Mary	land
	yland iow at		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	e Mar a-f st tified	ctor	MD St. M	lary's		St.	Ingoes						1 ☐Yes 2X No
	or 28	Director	10e. Street and Number 48620 Smiths D	12.13.10			10f. Zip Code	2068	o /,		10g. Citi	izen of What Cou USA	ntry?
	s 23a nust	eral	7117	1-	dent Ever in U.S	140 1	Mac Decedent of			acifu Van av Nu		14. Race - Americ	can Indian
_	fter de	Funeral	11. Marital Status  1 □ Never Married 2 □ Mar	Armed Fore	ces?	).	Was Decedent of f Yes, specify Cu	ban, Mexica	n, Puerto	Rican, etc.)	)-	Black, White,	
000	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes: '51-5	55	I∐Yes 2∭X N	Specify:				Specify: bla	ick
n n	72 hc 'natur dical	Completed	15. Deceder (Specify only highe	it's Education est grade completed)	ļ	16a. Deced	lent's Usual Occ kind of work don OO NOT use retii	upation e during mos	st of worki	ing	16b. Ki	ind of Business/In	dustry
7	within	Įd L	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L						c	
20	be filed value Hygie of other is event, the		17. Father's Name (First, Middle,	<del></del>			upnol	stere:	_	e (First, Middle		furnitur Surname)	e
au	ould be Mental arked c	To Be	Benedict	Smith				1	Marie	e Clayt	on	·	
ary	2 should and Men is marke aumatic	-	19a. Informant's Name/Relations				-					or Town, State, Zip	,
, Ma	1 and 2 Health em 27 i		Mark Briscoe/s	son								boro, MD	
altimore	Pages 1 and 2 should ient of Health and Men nt: If item 27 is marke ry or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (\$		tate 20b Pla	ace of Dispo emetery, cren	sition (Name of natory or other p	lace)		Date	20c. Lo	ocation - City or Te	own, State
pall	permit. Pages of Department of Himportant: If ite any injury or of once.		21. Signatur Paral Service	Wade )	ire						Ba1	timore S	Street
	4-11		23a. Part1. Enter the disease, o	complications that ca	used the death.		ltimore er the mode of d				arrest,		Approximate Interval Between
	Physician	i	shock, or neart failure. List Immediate Cau (Final disease or condition	only one cause on ea	ich line.	10	ncer	_					Onset and Death
	/Medical		resulting in death)	a. Due to (c	or as a seque	ence of):	ALCA						
	Examiner		Sequentially list conditions,	b									
	ted sit	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (c	or as a conseque	ence of):							
2	execunary and all-tran	Examiner	that initiated events resulting in death) Last	c Due to (c	or as a conseque	ence of):							
0/00	certificate be executed ding physician and ise as the burial-transit	dicall		d									
0	rtifica ng ph	Medi	IF FEMALE:										
א מ	ath ce ttendii	an/l	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Fetal	death 3	Ectopic pregnar	ісу			1.	23d. Date of deliv Month	ery Day Year
5	w requires that the death certifi been signed by the attending I should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregna 9☐Unkno	ant at time of dea wn	ath 5□	Other (specify)					WOTH	buy rour
7	that the ed by detac		Part II. Other significant conditi	ons contributing to dea	ath but not resul	ting in the u	nderlying cause g	iven in Part	l.	23e. Did	tobacco ı	use contribute to t	he cause of death?
	quires n sign ald be	d by								1 🗆	Yes 2	□ No 3□ Pro	bably 4 □Unknown
records	s bee	Completed								24a. Was		24b. Were auto	opsy findings available
	The law ate has boage 2 sh	mo	-			7.51 7				auto perf 1⊡ Yes	psy ormed? 2 <b>X</b> No	prior to co death? 1 □ Yes	mpletion of cause of 2 □ No
N I G	yslcian: The law lis certificate has b director, page 2 s	Be C	25. Was case referred to medica examiner?	1				26. Place	e of Death	n (Check only			
20	> .07 70	To	1 ☐ Yes 2 No	_		R/Outpatien	1 3 LI DOA					6 □Other (Speci	fy)
	ding Phys	ion:	27. Manner of Death  1	ig '	n, Day Year)	28b. Time of Injury	l W	ury at ork? ⊒ Yes 2 □		28d. Describe	how injui	ry occurred	
VISION	Attending r death. ector: After by the funer	ficat	2 Accident investi	not be 28e. Place o	of injury - At hon	ne, farm, str	eet, factory, offic			28f. Location	Street an	nd Number or Run	al Route Number,
	al or / s after il Dire	Certification:	4 ☐ Homicide determ	buildin	g, etc. (Specify)	)	,			City or To	wn, State	)	,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 11 Certifyin (Check only one)	ng Physician: To the la Examiner: On the ba	sis of examinati	rledge, death on and/or in	occurred at the vestigation, in my	time, date a y opinion, de	nd place, ath occur	and due to the red at the time	cause(s	) and manner as s d place, and due t	stated. to the cause(s)
	To the within compl	Me	29b. Signature and title of certifie					nse number			29d. Da	te signed (Month,	Day, Year)
			Much	el from	lene i		200	053z	09		3-	25-0	7
			30. Name and address of person Wendell Pic	who completed cause	of death (Item :	23a) (Type,	Print) HK Ro	ad r	line	lon m	0 50	25-0 0735	
ŝ	Sta		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatu	ure		, _					
	Registr	वा	MAR 2 9	2007	and do	· A	100	7.1					

DHMH 17 Rev 1/2001

ORIGINAL

Delores Stephens

				pe or Print in E								
			_ FOr	State of Marylan	d / Departme <i>Certifica</i>				')		10003	}
	2 2 2		State     Registrar  1. Decedent's Name (First, Middle, Last)		Certinica	le or i	Dealii	2. Date of De			3. Time of Death	
	Physicia	_	Delores B. Ste	phens				Month 03	25 Da	y Year 2007	11:55 P	М
	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)	4b. Cit	, Town, or	r Location of Death		4c	. County of Death	A	
			GOOD SAMARI	TAN HOS		3 A L er 1 Year	If Under 24 Hrs.	8 Date of Bir	rth	a Rint	hplace (State or Fore	ian
	Funeral Director		5. Social Security Number 6. Sex 1 1 N	1 2 XF 7. Age (in yis.	Yrs. Months		Hours Min.	(Month, Da	ay, Year)	44 Co.	untry) MD	gii
v ii	D.		Usual Residence of Decedent	40.00							10d. Inside City Lim	ite
	arylar ahow	7	10a. State 10b. County		y, Town or Location	•					1 XYes 2 ☐ I	
	the M	ecto	10e. Street and Number			ip Code			10g. Cit	tizen of What Co	untry?	
	n 72 hours after death with the Maryland "naturel", or Itema 23a or 28e-f ahow colcal Examiner must be notified at	Funeral Director	1808 Swansea	Road		2	1239			US	A	
	death	ner		. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	edent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White		
20	or Ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 🗆 Yes	2 No	Specify:			Specify: B	lack	
9500-c	72 hours after natural', or ite dical Examine		15. Decedent's Educa	tion	16a. Decedent's Us	ual Occup	ation		16b. K	(ind of Business/	ndustry	
ر ا	hin 72 9. Media	Completed	(Specify only highest grade of Efementary/Secondary (0-12)	completed) Colfege (1-4or 5+)	life. DO NOT	use retired	· ·	ang .	П	ealth	Care.	
7	filed within Hygiene. Ither than " int, the Me	Con	12th grade	2 years		neti	1100 18. Mother's Nam	- /Cirot Mindella			Lure	
משב	ba da	To Be	17. Father's Nache (First, Middle, Last)  Joseph B. Edr	nonds			Emma		s, Maider	1 Sumame)		
	2 should and Men is marke aumatic	۲	19a. Informant's Name/Relationship (Type		19b. Mailing Addre	ss (Street	and Number or Rui		oer, City	or Town, State, 2	Tip Code)	
Ma	nd 2 lith a 27 is r train		Mertis D. Stepha	ens/Husband	1808 51	Nan	sea Roa	d Ba		none MI		
ore,	ges 1 a it of Hea it Item or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  Re	1 ,	Place of Disposition (Notemetery, crematory of	other plac	ce)	Date		ocation - City or		
Баппо	Pa men ant:		4 □Donation 5 □Other (Specify)	Ki	ing Park C			107	W	indsor 1	Mill, MD	_
g	permit Depart Import any In		21. Signature of Funeral Service Licensee	M01363	The state of the s	and Addre	b Dand F	Laltime	ore	MD 212	eral Srvcs	
		-	23a. Part1. Enter the disease, or complication	ations that caused the deat		ode of dyir	ng, such as cardiac			1 17 212	Approximate Interval Between	
	Physician		shock, or heart failure. List only one fmmediate Cause (Final disease or condition	SEPS	T 5						Onset and Death	
F	/Medical		resulting in death)	Due to (or as a consec	quence of):							
	Examiner	<b>3.</b> .	Sequentially list conditions, b.	SACRAL Dua to for as a consequence		PBI	TUS	ULC	ER	25		
	pet usit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	juanice orj.							
,	e executed ien and rrial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):							
P8/P0		-1	d.									
	eath certificate b attending physic for use as the bi	Physician/Medica	IF FEMALE:			· · · · · · · · · · · · · · · · · · ·						
ХOЯ	attenc for us	lan/	in the past 12 mg/nths?	<ul> <li>If yes, outcome of pregnant</li> <li>1□Live birth 2□Feta</li> <li>4□Pregnant at time of control</li> </ul>	al death 3 Ectopic		у		- 1	23d. Date of del Month	Day Year	
o.	by the a	nysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							_	
o,	res that igned to be deta	by P	Part II. Other significant conditions conti	ributing to death but not res	sulting in the underlying	g cause giv	ven in Part I.				the cause of death?	
ecords,	w require been sig should b	ted	End Stage	Kenal	disease	2		1 🗆	Yes 2	2 <u>□ 1</u> 10 3 □ Pr	obably 4 Dunkno	wn
ĕ	a taw r has be e 2 sh	Completed	Diabetes Me	ellitus					s an opsy formed?	24b. Were at prior to death?	topsy findings availa completion of cause	ible of
ᇛ			Stroke_		-			1□ Yes	2 14	0 1 ☐ Yes	2 No	
of Vital H	ysicial is certii directo	To Be	25. Was case referred to medical examiner?	spital: 1 Unpatient 2	ER/Outpatient 3	DOA Oth	26. Place of Dea			6 ∏Other (Spe	cify)	
0	ding Phy h. After thi funeral		27. Manner of Beath	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo		28d. Describe				
S S	Attendir death. ctor: Af y the fu	catlo	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 🗀	Yes 2 □ No		(0)		10.4.1	
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Injury - At h building, etc. (Speci	iome, farm, street, fact fy)	ory, office		28f. Location City or To	(Street a	and Number or Hi te)	ural Route Number,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;		29a. Certifier 1 Certifying Physi	cian: To the best of my kn	owledge, death occurr	ed at the ti	me, date and place	, and due to the	e cause(	s) and manner a	s stated.	
	he Ho n 24 h he Fu	Medical	(Check only 2 Medical Examinations)	er: On the basis of examination and manner stated.	ation and/or investigati	on, in my	opinion, death occu	rred at the time	, date ar	nd place, and due	to the cause(s)	
	With To t	Σ	29b. Signature and title of certifier	<u></u>	1 0	29c. Licens	se number	2		ate signed (Moni	-	
ľ .	V		> Allingoran		1. D.	1				3-27-	200/	
(	7		30. Name and address of person who con		m 23a) (Type, Print)			MIN	0	RANI		
	⊘ Sta	te	31. Date filed (Month, Day, Year) MAR 2 9 2007	32. Registrar's Sign	ature	1 -	OND	1-10				
100	Registr	ar	MAR 2 9 2007	A STATE OF THE STA	1							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Theodore **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday Date of Birth **Funeral** Days Months Hours 1 XM 2 ☐ F 0170471961 213-72-3142 Director 46 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23a or 28a-f show ner must be notifled at Director 1 ☐ Yes 2 ☐ No MD BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7920 SCOTTS LEVEL ROAD 21208 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MICHAEL SAMUEL SANDERS DIANA 2 CHARNEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACOB SANDERS / BROTHER 2716 WOODCOURT RD., BALTIMORE, MD 21209 Baltimore, 20b. Place of Disposition (Name of AGUDATH TSRAEL OF 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/28/2007 BALTIMORE, MD BALTIMORE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Lev 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Se ventially list con tions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes □ No 24a. Was an certificate has autopsy Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217/10 Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To Date of Injury (Month, Day Year) 27. Manner ath 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Iniury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certifier

MAR 2 9

30. Name and address of person who completed cause of death (Item 23a), ANURADHA REDDY 821

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

	Ph /I Ex	ysicia Medica amine
. Box 68760,	death certificate be executed	e attending physician and set for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.

Division or Vital Records, P.O. # 30

For		e Type or Prin	ndand / D	epartm	ent of H	ealth and			9	10005
7 - State Ame Registrar	ena #30, per	rDVR G865, 3/29	9/U/ II	Certific	cate of L	Death		Reg. No	FUUI	10003
1. Decedent's Na	ime (First, Middle,	Last)					2. Date of			3. Time of Death
LISETT	E			S	CHEUER		MARCH	2 <sup>Da</sup>	<sup>y</sup> 2007	8:21 PM
		give street and number)				Location of De			County of Deat	
		E APT. #216		R	ALTIMO	RF			RAI T	IMORE
5. Social Security			(In yrs. last birt		Inder 1 Year	If Under 24 H		Birth		
216-03-	4902	1□M 2□F			nths Days	Hours M	06/30/	Day, Year,	Co	hplace (State or Foreign untry) MD
10a. State	10b. County	IMORE	10c. City, Town	or Location						10d. Inside City Limits 1 ☐ Yes 2 No
10e. Street and I	Number DE AVE AF	DT #216		10	f. Zip Code	00		10g. Ci	tizen of What Co	
				140.111	212		10 11 11	<u> </u>	U.S.A.	
	s arried 2□ Married d 4□Divorced	12. Was Decedent E Armed Forces? d 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:			specify Cuba	Ispanic Origin? In, Mexican, Pi Specify:	(Specify Yes or uerto Rican, etc.)	No-	Black, White	
(S)	15. Decedent's pecify only highest	Education grade completed)	16a.	(Give kind )	Usual Occup	luring most of	working	16b. k	(ind of Business/	Industry
Elementary/Se	econdary (0-12)	College (1-4or 5	+) Н	OMEMA	OT use retired KER	)			OWN HOM	1E
17. Father's Nam	ne (First, Middle, La	ıast)				18. Mother's f	Name (First, Midd	dle, Maider		
HENRY	· · · · · · · · · · · · · · · · · · ·	•	SONNEBOR	N .1D		LILLI	, ,	_,		HAMBURGER
	Name/Relationship				dress (Street		Rural Route Nui	mber. City	or Town State 3	
ANN NEU	MANN LIBO	V/DAUGHTER	11	SLADE	AVENU	E APT.	#201 -	BALTI	MORE, M	D 21208
		B □Removal from State ecify)	20b. Place of cemeter BALTIM	Disposition y, cremator ORE H	(Name of y or other place EBREW	03/	<sup>28/2007</sup>	1	TIMORE,	
2 Signature	Funeral Service Lie	Xemine	,		ne and Addres		SOL LEV: NN ROAD			, INC. , MD 21208
Inmediate Caus disease or cond resulting in deat Sequentially list if any, leading to Cause (Disease that initiated eve resulting in deat	ce (Final tition h)  conditions, immediate or injury or injury nis	b	To .	of):						Interval Between Onset and Death
IF FEMALE: 23b. Was deced in the past 1 ☐ Yes 9 ☐ Unkno	12 months? 2 🗆 No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal death		pic pregnancy er (specify)	,		-	23d. Date of del Month	ivery Day Year
Part II. Other sig	nificant condition	s contributing to death bu	ut not resulting in	the underly	ring cause giv	en in Part I.			/	the cause of death?
							24a. W au pe 1∐ Ye	/as an utopsy erformed?	24b. Were au prior to death?	utopsy findings available completion of cause of
25. Was case re	ferred to medical					26. Place of	Death (Check on			1
examiner? 1 □ Yes 2	No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Out	tpatient 3	DOA Oth	er: 4 🗆 Nursin	ng Home 5 ⊠ R	esidence	6 □Other (Sne	cifv)
27. Manner of D 1 ★Natural 2 ☐ Acciden	eath 5 □ Pending t investiga	28a. Date of Inju (Month, Da)	ry 28b. T	Time of njury	28c. Injur Worl		28d. Descril			
3 ☐ Sulcide 4 ☐ Homicid	6	28e. Place of inju- building, etc	iry - At home, fai c. (Specify)	rm, street, f	actory, office			n (Street a Town, Stai		ural Route Number,
29a. Certifier (Check only one)	1  Certifying 2  Medical E	Physiclan: To the best of xaminer: On the basis of and manner sta	examination an	, death occ d/or investi	urred at the tir gation, in my c	ne, date and p pinion, death o	lace, and due to to occurred at the tir	the cause( ne, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
29b. Signature a	and title of certifier	Alpha-	MΛ		29c. Licens	e number 50 5 9 2			ate signed (Mont	
30. Name and a		ho completed cause of de	eath (Item 23a) (	Type, Print	_			1.10	, , , , , ,	( ) ( )
		D Lutherville,								
	fonth, Day, Year)	32 Registra	ar's Signature		A					
	MAR 2 9	2007	ar's Signature	goard						
	*	7		*						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Z3, ZUV7 **Physician** Dorothy Marie Templeton /Medical Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore washington Martical MY GP Annl Burnin 8. Date of Birth Oct Month Play, Year 1919 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 214-12-9304 1 M 2005 87 MaryTand Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26 Stevens Road 21060 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1044 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 √Xes 2 No 1944— If Yes, Give Year or Dates: 1946 Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify ۵ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Robert Alice Sopie Hinners Hood ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061Gary Templeton / Son 205 Westport Bay Drive Apt. 304 Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Mar. 27, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 Donation 5 Dother (Specify) Glen Haven Mem. Pk. Glen Burnie, MD 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A.
421 Crain Hwy. S.E. Glen Burnie, Md 21061 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or components that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) O 9 Unknown Vital Records P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 (No 24a. Was an autopsy perform After this certificate 1☐ Yes or Attending Physician; 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Unpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

Registrar DHMH 17 Rev 1/200

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print

100

301

🌠. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 4:20 PM Umberger MArch 2007 Marion /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 7107 Eastbrook Avenue | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Nov. 3, 1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 KF 218-22-4922 98 YES PA **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ahow rthan "naturat", or Itema 23a or 28a-f ahov the Medical Examinar must be notified at 1 ☐ Yes 2 🛣 No MD Baltimore Baltimore Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 7107 Eastbrook Avenue 21224 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White \$ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 9th permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 27 is marked oth-any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Travis Ida Savicoll 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9011 Chateaugay Court Baltimore MD 21234 Caesar Chiappini /son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 3/27/07 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura d Funeral Service Libense 22. Name and Address of Facility 300 Mace Ave. Balto. Md Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each une. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE Week /Medical Due to (or as a consequence of): Examiner 20 Years CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 22 No ō Month Day Year 4 Pregnant at time of death 5 Other (specify) o detached 9 Unknown à ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Aortic Stenosis Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? page certificete 20 No 1 Yes 2 No 1 Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification; Division or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours efter death.

To the Funeral Director: A
completely filled in by the fu М investigation 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tha Hospitei 19 Certifying Physician: To the best of my knowledge, death oncurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifica Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 27, 2007 D17728 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21236 8022 Belair Rd. Ba Yin Oung, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 9 2007 Registrar

		•	For State Registrar	110000	State of	f Marylan	-	artment of			lental Hygi	ene	7	10008
			Decedent's Name	(First, Middle, La	ast)						2. Date of Death		Vace	3. Time of Death
	Physici		Henr	У	L.	Vе	nson				Month 3 26	200°	Year 7	0852 M
	/Medio Examin		4a. Facility Name (If I	not institution, gi	ve street and nun	nber)		4b. City, Town,	or Location	of Death		4c. County		
	LAdillil	C1			an Hos			Bal	timor	е			N/A	
20/02	Funeral Director		5. Social Security Nur 250-54-	mber 6.		7. Age (In yrs. 69	last birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Birth (Month, Day, 7 26	<sup>Year)</sup> 37	9. Birth Cou	place (State or Foreign ntry) S.C.
00	ъ.		Usual Residence of I				y, Town or Lo	eation						10d. Inside City Limits
20	a-f show	ctor	10a. State MD	10b. County	/ A		Balti							1 Yes 2 No
200	titled within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then "natural", or Items 23a or 28a-f show ant, the Mardical Examination notified at	Completed by Funeral Director	10e. Street and Number 1625		n Stree	t		10f. Zip Code	21218	3	10	og. Citizen of ' U	What Cou SA	ntry?
1 10	fter deat	Funer	11. Marital Status 1 Never Marrie	nd <b>2</b> (Married	Armed Fo	2 X No		Was Decedent of If Yes, specify Cu			ecify Yes or No- Rican, etc.)	Bla	ck, White	
7	ours aft	ξ	3 Widowed 4	1 Divorced	If Yes, Giv Year or D	ates:				•		Specif	נכו	ack
7 \	i within 72 hours iene. r then "natural", the My digal Ex	pletec	(Specif		Education trade completed) College (1	I-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	upation le <i>during mos</i> red)	st of work	ing	16b. Kind of B		ndustry
2 2	filed with Hygiene. ther ther	Con	6th		N/	Α	Dis	sabled	40.34.4		April 10 A A A Saladata A		/A	
Je 1		To Be	17. Father's Name (F Joseph		Vin	son					e (First, Middle, M ah			
), He	2 sh and Is m		19a. Informant's Nar Geraldii			e	19b. Maili 1625	ng Address <i>(Stre</i> 5 Chilt	et and Numb on St	er or Run	a <i>l Route Number</i> t Balti	City or Town	, State, Zi MD	21218
SO 1	ages 1 and 2 nt of Health : if Item 27 I			Cremation 3	☐Removal from	_	emetery, cre	osition (Name of matory or other p	lace)		Date /31/07	20c. Location Balti		
2 N S O	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tigns.		* 4 □ Donation			GI	2	2. Name and Add	ress of Facil	ity MA	RCH FUI	NERAL		E-EAST MD 21202
1	adsea	1	23a. Part1. Enter th shock, or hear	e disease, or on t failure. List on	mplications that of	caused the deat							)LC/	Approximate Interval Between Onset and Death
0	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	Final	a Due to	was a consec	vence of):	inchaif	10	puc	fu		-	1 hour
092	tie be executed be executed by sician and burial-transit	cal Examiner	Sequentially list con if any, leading to inu- cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	injury	c.	or as a consec		n						years
, o	box outsitical authorous contributions at the for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	months?	1 ☐ Live t	tcome of pregnorth 2 Feta nant at time of coown	aldeath 3	□Ectopic pregna □ Other (specify,			111		ate of deli	very Day Year
	uires that the signed by d be detac	by	Part II. Other signifi	0.0	s contributing to d	leath but not res	sulting in the i	underlying cause	given in Part	I.	23e. Did to		atribute to	the cause of death?
obygona priviles	The taw requir	Completed									24a. Was a autops perform	sy	Were au prior to death?	topsy findings available completion of cause of
	vician: Th ician: Th certificate rector, pag	Be	25. Was case referr examiner?	red to medical	Hospitali		/		Other		th Check onl or		-	
<b>-</b>	ng Phyaician: ter this certific	on: To	1 Yes 2 2 27. Mann of Death 1 atural			Inpatient 2 of Injury 1th, Day Year)	ER/Outpatie 28b. Time Injury	of 28c, Ir	njury at Vork?	lursing H	ome 5 Resid			cify)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 4 Homicide	investigat 6 Could no determine	t be 28e. Place	e of Injury - At h ling, etc. <i>(Speci</i>	nome, farm, s	M 1 treet, factory, offi	Yes 2	⊒No	28f. Location (S City or Tow		iber or Ru	ral Route Number,
	Hospital 24 hours Funeral stely filled	edical Ce	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the taminer: On the tand man	and all automia	ation and/or i	nucetication in F	w oninion de	agth occur	rrod at the time of	late and place	and due	to the cause(s)
		Med	29b. Signature and	title of certifier	Aus			29c. Lic	ense number	-1/3	2	29d. Date sign	ed (Monti	n, Day, Year) 9, Low 7 21737 Maylant
	19		Bell	seer & C	7-				ソコララ	)43	/	- year p		2/2 35
	4		30. Name an addre	ess of person wi	n completed cau	ise of death (Ite	m 23a) (Type	Lack F	a vez	Bui	levand)	Bil4	mar	Mayland
	21	ate	31. Date filed (Mont	th, Day, Year)	32	Registrar's Sign	ature	2						/ /
	Regist		R/	MAR 2 9	2007	Eur 1	OF A	seci.						

		•	State of Maryland / Department of Health and N  - State Registrer Certificate of Death		ne No. 007	10009
	۰	14.	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Luzia Vinerts	March	23 2007	2:40 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	<i>r</i> / \
			Social Security Number 6 Sex 7 Age //n vrs. last birthday   If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Bultomore	
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F  7. Age (In yrs. last birthday)   H Under 1 Year   H Under 24 Hrs.    Wonths Days Hours Min.	Dec. 15,	1920 Ger	lace (State or Foreign htry) MANU
			Usual Residence of Decedent	10000		
	nylan show	_	10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits 1 ∰Yes 2 ☐ No
	Ba-f s	Director	Maryland N/A Baltimore	100	. Citizen of What Cour	
	ter death with the Marylan Itams 23a or 28a-f show Itati: rust be notified at	ä	10e. Street and Number 3204 Rosekemp Avenue 21214	109	U.S.A.	uy:
	ns 23	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - Americ	
39	4 within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-f show the Medical Evanti activust be rediffed at	by Fur	Armed Forces?  1 Never Married 2 Married In Sec. 1	Hican, etc.)	Black, White,	ite
2-0	72 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of won	lein a	b. Kind of Business/In	•
21	within iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		self-Employ Sakery	red
2	filed w Hygie other t			ne (First, Middle, Ma		
Maryland 21215-0036	ed tal	To Be	Webmeister O. Thiele Anasta		andr	
Mar	s 1 and 2 should of Health and Men itam 27 is marka other traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			Code)
	1 and 2 Health Iam 27 i	- 5	Kenneth Kellogg (friend) 241 Carvel Road, Pasac 20a. Method of Disposition (Name of		21122 c. Location - City or To	own, State
nor	0 0		cemetery, crematory or other place)		altimore, N	
Baltimore,		i	21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Ba	permit. Departr Importa any inji		9705 Belair Rd.,			
	10		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest	,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)  a. Chroni Read Pailure  Due to (or as a consequence of):			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-
Y	uted 3 ansit	Examine	cause. Enter Underlying Cause (Disease or injury			
ر 0	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	ate he	Physician/Medical	d			
9	ertific ding pl	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of delive	
Вох	eath certific attending pl	cian/	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  5 Other (specify)		23d. Date of deliver	Day Year
o.	at the de by the a tached	nysi	1 □ Yes 2 No 9 □ Unknown 9 □ Unknown		1	
0.	es that igned b be deta	by Pl	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ıd	w require been sig should b	ted t	ischanic heart disease	1 ☐ Yes	2. No 3 □ Prot	oably 4 □Unknown
Vital Records,	e law re has be je 2 sho	Completed	(09)	24a. Was an autopsy	prior to co	psy findings available impletion of cause of
H		Con	Demenha	performe	d? death? No 1 ☐ Yes	2□ No
Vita	Physician: The this certificate ral director, pag	Be	examiner? Hospital: Other	th (Check only one)		
of	Phys r this ral dii	. To	1 Yes 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Will 4 Nursing H	ome 5 Residence 28d. Describe how	ce 6 Other (Special injury occurred	ý)
on	Attending Phy or death. actor: After thi by the funeral or	tion	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division	or Attendi after death. Diractor: A in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,	et and Number or Rura State)	al Route Number,
	rs after al Dirac	Cert	Parally, Co. (epecary)			
	To the Hospitel or At within 24 hours after or To the Funaral Diract completely filled in by	edicai	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place countries and place countries are considered.  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place countries are considered.			
	To tha   within 2 To the   complet	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Month,	Day, Year)
			What Klus no D 31295		3/23/07	-
	le		29c. License number  29c. License number  D 3/295  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Wandy Klorst Groin Charles SA Suk 42c 2  31. Date filed (Month, Day, Year)  MAR 2 9 2007  32 Registrar's Signature	TOWSON	md =	7204
*	Sta Registi		31. Date filed (Month, Day, Year)  MAR 2 9 2007  32 Registrar's Signature			
		· A 40	s.t.Pa. Aid a			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7,2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Jary/and altimore Year If Under 24 Hrs. 8. Date of Birth Month, Day. Grener 5. Social Security Number If Under 1 Birthplace (State or Foreign 6. Sex **Funeral** Months 1 □ M 2 🕱 F Director rainia Usual Residence of Decedent with the Maryland 10c City Town or Location 10d Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 must be n 21 Funeral 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status an "natural" or item Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ac Maryland 21215-003 Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental 19a. Informant's Name/Relationship (Type. Print) (nephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important; If item 27 is any Injury or other trae once, 20a. Method of Disposition Baltimore, 20b. Place of Disposition (Name of Pages Then Pages 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signat re of Funeral Service License 23a. Part / Enter the casease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner that the death certificate be executed and burial-trar Due to (or as a consequence of). physician Physician/Medical the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 sl autopsy performed 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 ER/Outpatient 3 DOA P 1 Inpatient this After this funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fo 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier raminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of cert 29c. License number (Month, Day cause of death (Item 23a) (Ty 30. Name and addr

State Registrar

Registrar

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

& Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5,53 am Mildred L. Weese /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ва timore Franklin Sq 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🖫 F 76 234-40-3775 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore MIddle River Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21220 USA 511 Apt.D Bowleys Quarters Road Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Specify:White 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within International Elementary/Secondary (0-12) College (1-4or 5+) Inspector 12th Paper Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked other any Injury or other traumatic event, once. Maryland Be Luther L. Weese Maud Key ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Weese /brother 4600 Michigan Drive Little Rover SC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 3/26/07 Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed as the burial-trai Due to (or as a consequence of): in Blood Coryne bac terium IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Colon Cancer, bladder Cancer, CAD, S/P 1 🗌 Yes 2 No 3 Probably 4∕√Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 25. Was case referred to medical examiner? 1□ Yes 2X No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 ☐ Pending investigation Natural Accident Injury 1 ☐ Yes 2 ☐ No al or Attend after death 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier des Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 2 9 2007

State of Maryland / Department of Health and Mental Hygiene 0 0

			1 = State Registrar			Certificate of	Death	Ra	ag. No,	
	L		1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month		3. Time of Death
	Physici /Medio		Warren W	ertman				March	<sup>Day</sup> 25 2007	10:00 AM
	Examir		4a. Fecility Name (If not institution, giv	e street and number	)	4b. City, Town,	or Location of Death		4c. County of Death	
			North Arundel	Rehab (	Center	Glen	Bernie		Anne Aru	ndel
	Funeral Director		5. Social Security Number 203-16-0751 6. S	Sex 7.A ⊠M 2□F	ge (In yrs. last birth	day) It Under 1 Yea Months Day:		8. Date of Birth (Month, Day, July23		lace (State or Foreign try)
	P .		Usual Residence of Decedent		100 City Town					and the state of the state of
	ehov	_	10a. State 10b. County  MD Balti	mono	10c. City, Town				10	0d. Inside City Limits 1 ☐ Yes \$☐ No
	Sea-f	octo		more	Esse					
	a within 72 hours after death with the Maryland Jiene. r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at	al Director	174 Riverside	Road		10f. Zip Code 212	21	1	0g. Citizen of What Coun USA	try?
	dea F	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. Was Decedent of It Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
21215-0036	ours afte rel', or it Examin	by	1 Never Married 25 Married 3 Widowed 4 Divorced	1 <b>Ty</b> Yes 2 □ If Yes, Give Year or Dates:	No	1 □ Yes 2 🙀 No			Specify: Whi	
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anc	be fi	Be	17. Father's Name (First, Middle, Last,  Carl Leroy W					a Nuner		
Ĕ	should be nd Menta nmarked umaric ev	2	19a. informant's Name/Relationship (		10h I	Apilian Addraga (Street			, City or Town, State, Zip	Code
Maryland	alth an 27 le r		Nancy Cramer	/ daught					le Marylan	
	He He		20a. Method of Disposition	, adagii	20h Place of F	Disposition (Name of			20c. Location - City or To	
Baltimore,	8 = 5		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	(y)	Lake V	crematory or other pl	etery 3/3	30/07	Baltimore	MD
Ba	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Lice	Pw	$\sim$	22. Name and Add	3(		Ave. Balt of Essex	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceuse one cause on each	d the death. Do no	t enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Same	~ CHI	= 1,714	left in	int. 46	W. Jan	Onset and Death
1	/Medical		resulting in death)	Due to (or as	s a consequence of	):	11100	V -		Seller
4	Examiner		Sequentially list conditions.	p. Por	p. dis	hen .	ulso- 2ª	7 00	PD.	munde
14/	od it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequence of	):		,		
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387	phys the	/Medical		d						
×		/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date of delive	D.
Box	death atter	Physician	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ☐ Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			Day Year
P.O.	the cy the ached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	The law requires that the death ste hes been signed by the atter page 2 should be detached for u	by Pi	Part II. Other significant conditions of	contributing to death	but not resulting in t	he underlying cause g	iven in Part I.	23e. Did tob	pacco use contribute to th	e cause of death?
Ę	quire on sig uld b	pa pa	-1)m.	CAI	) .	ATN	,	1 □ Ye	as 2 □ No 3 □ Frob	ably 4 □Unknown
ပ္ပ	s bee	Completed						24a. Was a	n 24b. Were autor	osy tindings available
æ	The la	E O						autops	ned? death?	npletion of cause of
tal	an: ] tifice tor, p	BeC	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes 2		2 No
<u> </u>	Physician: r this certifice ral director,	ToB	examiner? 1 ☐ Yes 2 ₺ No	Hospital:	ient 2 ER/Outp	eatient 3 DOA			once 6 □Other (Specify	()
ठ	g Ph er thi		27. Manner of Death	28a. Date of Inj (Month, Da		ne ot 28c. Inj			ow injury occurred	,
ō	Attending ir death. ector: After by the fune	atle	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation		ay rear/ Ing		Yes 2 □No			
Division of Vital Records,	er de recto	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of in	njury - At home, farm	n, street, factory, office	,	28t. Location (St. City or Town	reet and Number or Rural	l Route Number,
۵	rs after or sell or se	Cer							,, 5.12.0,	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 Cartifying Pt (Check only 2 Madical Examone)	nysician: To the best ninar: On the basis and manner s	of examination and/	death occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as sta ate and place, and due to	ated. the cause(s)
	Withir To the Comp	M	29b. Signature and title of certifier	, ,	7	29c. Licer	ise number	29	9d. Date signed (Month, L	Day, Year)
	<u></u>		miss	ales 4	<u></u>	0	6437	2	3/97	107
	9		30. Name and address of person who	completed pause of	death (Item 23a) (T	ype, Print)			7/2/	1
_			Harbos hos	nitral =	3001	South	Hamo	ner &	212:	2_5
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1 3				

DHMH 17 Rev 1/2001

Registrar

MAR 2 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Hegistrar

State of Maryland / Department of Health and Mental Hygiene Hegistrar

State of Maryland / Department of Health and Mental Hygiene Hegistrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 32P WHITE-BE KUDOLPH Jarch 2007 /Medical 4b. City, Town, of Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Avenue Baltimore hinden If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Months 1**X** M 2□ F Yrs. Director MAR Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 XYes 2 No Funeral Director Dec: Rudolph Whik-B r must be notified 10e, Street and Number Citizen of What Country? 242 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Medical Examiner 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💆 No Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the M MINISTRATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Department of Health Important: If item 27 any Injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State SON FOREST 04-04-01 OWINGS MILLS 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avenue MO 21217 f Funeral Service Licens 21. Signatur Jr. Luneral Home Part 1. Envey the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NIETASTATIC ARCINOUA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit The law requires that the death certificate be executed Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Division or Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HY MOMP 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of the Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation Injury after death.

Director: Aff in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) NKever +SICPAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAN 440 M 3100 LEPED Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fth 9866 4-27-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Whitaker 7:45 人M 26 2007 lerr Mar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NIA University of Maryland Medical Center City 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) (State or Foreign 5. Social Security Number **Funeral** Min. Days Hours Months 1 M 2□ F MD. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 des 2 No MD. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 5. Funeral 14. Race - American Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 64-65 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LEC OX 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 1909). 1/10 19a. Informant's Name/Relationship (Type.\_Print) ER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition olace) 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. S nature Frineral Service Licensee ite 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) atelectasis and sepsis **Physician** Aspiration pneumonitis and One week /Medical Due to (or as a consequence of): xaminer One month hapatohydrotherex and empyema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): physician Physician/Medical use as t attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. – s been signed by the s 9□Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by Renal failure 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No failure 24a. Was an Liver cate has 1, page 2 s autopsy performed? res 2 No 1∐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 일 2 No 2 ER/Outpatient 3□ DOA 1 Tes 1 Inpatient this funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending After Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 B. Himore

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 9 2007

32. Refistrar's Signature

ROBALS.

		Ple	ease Type or Pri		ndelible Ink.			-	
		For State Registrar	Otate of W		ertificate of			g. No.2	10015
Physici /Medio		1. Decedent's Name (First, Mic Edna	<sup>ddle, Last)</sup> Murier Wilc	gis			2. Date of Death Month March 2	Day Year	3. Time of Death  10:43 A <sup>M</sup>
Examir		4a. Facility Name (If not institu Home; 2641				r Location of Death	1	4c. County of Dear	th
Funeral	1	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthda	ay) If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9 Bir	thplace (State or Foreign ountry)
Director	ž.	213-58-4025 Usual Residence of Decedent			•		7-01-19	910 Ma	ryland
Marylan f show ed at	o	MD 10a. State 10b. Cour	nty N/A	10c. City, Town or	Location  Baltimor	<b>^</b> _			10d. Inside City Limits 1 □XYes 2 □ No
ith the lor 28a-	Funeral Director	10e. Street and Number	11/ 11		10f. Zip Code		10	g. Citizen of What Co	Juntry?
leath w ns 23a must k	eral	2641 Hampde	n Avenue	t Ever in U.S. 1		21211 Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ M  3 ☐ Moved 4 ☐ Divorce	Armed Forces'	? ₫No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※※ No		Rican, etc.)	Black, Whit	white
in 72 ho 1 "natu ledical	Completed	(Specify only hig	dent's Education thest grade completed)	(Gi	cedent's Usual Occup ive kind of work done e. DO NOT use retired	nation during most of work d)	ring	6b. Kind of Business	Industry (Industry
ed with ygiene. ner thar t, the N	Com	Elementary/Secondary (0-12		5+)	Homemak	ker		In own	home
lld be fil lental H <b>ked ot</b> t ic even	To Be	17. Father's Name (First, Middle George Wesl	·			18. Mother's Nam Flo		<sub>laiden Surname)</sub> H. Layton	1
12 shou h and M 7 is mar raumat		19a. Informant's Name/Relation Dora Wilgis			-			City or Town, State,	
ss 1 and of Healt Item 27 other 1	3 4	20a. Method of Disposition		20b. Place of Dis	2041 nall	i		cimore, M	
t. Page rtment o rtant: If		4 □ Donation 5 □ Other			and Memor	ial 3/3	1/2007	Baltimor	•
permi Depar Impor any ir		21. Signature of Funeral Servi	ice Libensee	lin	Burgee-F 3631 Fal	ienss-Se Lls Road	itz Fur Balti	neral Hom More, MD	le 11211
		23. r n1. Emer the dise shock, or heart failure. Immediate Cause (Final	or complications that cause st only one cause of each l	ed the death. Do not of ine.					Approximate Interval Between Onset and Death
Physician /Medical	× 11	disease or condition resulting in death)		refers a consequence of):	m				gears
Examiner	er	Sequentially list conditions,	b. Due to (or as	General consequence of):	Least Ja	eleere			2 years
executed in and ial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c. De	meuna					Tyean
be icia bur	<u></u>	resulting in deality Last	Due to (or as	s a consequence of):					
ertificate ling phy e as the	Medic	IF FEMALE:							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the law to the funeral director.	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
equires that en signed b ould be deta	by	Part II. Other significant cond	litlons contributing to death I	but not resulting in the	e underlying cause giv	en in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2 □ No 3 □ P	o the cause of death?
: The law recate has be page 2 she	Completed						24a. Was an autopsy perform	/ prior to	utopsy findings available completion of cause of 2 \( \square\) No
ysician s certifi director	To Be	25. Was case referred to med examiner?  1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/Outpat	tient 3 DOA Oth	er.	h (Check only one	nce 6 □Other (Spe	city)
ding Phy J. After thi funeral (		27. Manner of Death 1 Natural 5 □ Pen	28a. Date of Inj	ury 28b. Time ay Year) Injur	e of 28c. Injury		28d. Describe ho		ury
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be	jury - At home, farm, tc. (Specify)	7	res 28 No	28f. Location (Str City or Town	eet and Number or R. State)	ural Route Number,
e Hospita 24 hours e Funeral letely filled	Medical C		rying Physician: To the best cal Examiner: On the basis of and manner s	of examination and/or					
To th within To th	Me	29b. Signature and title of cert	ifier reute Fron	an Mi	29c. Licens			d. Date signed (Mont	
27		30. Name and address of pers	on who completed cause of	death (Item 23a) (Typ	pe, Print)	11 1	1011	3-28-	2010
Sta	te	31. Date filed (Month, Day, Ye	ar) 32. Regist	ANION M	emonal	MUSPITA	Dalt	more, Il	121218
Registr	ar	MAR 2 9 2	2007	AS APPEA					

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		-	State of Marylan					•	
		1 _ State	State of Ivial ylari		tificate of			2007	10016
		Registrar  1. Decedent's Name (First, Middle, Last)			inoate or	Death	2. Date of Death	g. Nó 💚 💚 🔏	3. Time of Death
Physic		James Williams					March	Day Year	1 5:00 AM
/Med		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, o	r Location of Death	FICTOR	4c. County of Dear	
		SALISBURY REHAB	& NURSING C	ENTER	SALIS	SBURY, MD.		WICO	MICO
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 5,	Year) 9. Birt	hplace (State or Foreign
Directo		Usual Residence of Decedent	81	115.			Jan 5,	1926   Ind	iana
show		10a. State 10b. County	10c. City	, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
e Mar e-fsl	ctor	MD Wicomico	Sa	alisbu	rу				1 □ Yes 2√ No
ith the M. or 28e-f	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
Signature (1992)	ra	200 Civic Avenue	144	2 42 1		21804	7 77	USA	death to the
Ter de	-un	11. Marital Status 12  1 □ Never Married 2 □ Married	. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 2 M No.	5.   13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
fay) Soose oos6 hours after death with the Maryla turer; or Items 23a or 28e-1 show at Examilrer must be notified at	by	3	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify: Wh	ite
1215-0036 within 72 hours after death with the Maryland ene. "naturel", or items 23a or 28e-1 show item "naturel", or items 23a or 28e-1 show item "naturel", or items 23a or 28e-1 show items 23a or 28e-1 show items 23a or 28e-1 show items 25a or	Completed by Funeral Director	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deced	ent's Usual Occup	ation during most of working	1	6b. Kind of Business	Industry
21215-0 1 within 72 ho giene. r then "natur	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)						
T Page 1	ပိ	12 17. Father's Name (First, Middle, Last)	0	seli	employee	d 18. Mother's Name		grocery st	ore
De pe	To Be	Harve Williams				Ella Ev		aldon Samano,	
re, Marylanc s 1 and 2 should be t Health and Mental I trem 27 is marked of	-	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street			City or Town, State, 2	Zip Code)
2 2 g = 2 2	1	Loy Godfrey/daughte	r	3182	Road 14	Harrisbur	g, NE	69345	
Nore,	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren		ace of Dispos	sition (Name of natory or other place	Da Da	ate 2	0c. Location - City or	Town, State
altimor mit. Pages bartment of a		*4 □ Donation 5 X Other (Specify)	n state						
Baltimore, permit Pages 1 at Department of Hea Importent: If item amy nigury or othe		21. Signature Funeral Sary to Licensee	dy, hirector	St Ba	Name and Address ate Anato 1timore,	ss of Facility Omy Board MD 21201	655 W.	Baltimore	Street
,		23a. Part . Enter the disease, or complica shock or heart failure. List only one	tions that caused the death					st,	Approximate Interval Between
Physician	*	Immediate Cause (Final disease or condition	(MODER		2 /	2	- 0 29		Onset and Death
/Medical Examiner	_	resulting in death)	Due to (or as a consequ	egog of):	1	1		1	Jua 2
Examine		Sequentially list conditions, b.	Kan for	Ken	1 0	ar carlo	¬ ~	neone	42000
fed	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence ot):	•	,			
60, be execuician and	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):	un				yeus
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687 rtificate ng phys as the	Medi	IC CCMAIR							
Box 68 Box lose tilica attending ph	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal		Ectopic pregnancy	,		23d. Date of del	
Division of Vital Records, P.O. Box 68 or or Attending Physicien: The law requires that the death certifical after death. Director: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	by Physiclan/Medl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5□	Other (specify)			Month	Day Year
cords, P.O.  wrequires that the dipensioned by the should be detached	Phy	Part II. Other significant conditions contri	buting to death but not resu	Iting in the un	deriving cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
'dS, P ruires tha n signed b	d b				, ,		1 405	2 No 3 Pr	obably 4 Unknown
COr( w requ	lete						24a. Was an	24b. Were au	topsy findings available completion of cause of
Re In The late has age 2	Completed						autopsy perform	ed? death?	completion of cause of 2 \( \subseteq \text{No} \)
ital	BeC	25. Was case referred to medical examiner?				26. Place of Death			2 110
of V hysic his ce	2	1 Yes 2 No		R/Outpatient		4 Nursing Hom	ne 5 ☐ Residen	ce 6 □Other (Spe	cify)
on C ling P After I	lon:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl		8d. Describe hov	v injury occurred	
isic ttend death ctor:	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	me farm stre		Yes 2 □No	8f Location (Stre	eet and Number or Ru	ral Route Number
Division of Vital Records, P.O. Box 68 Hospitel or Attending Physicien: The law requires that the death certifica 1.4 hours after death. Funeral Director: After this certificate has been signed by the attending ph tely filled in by the funeral director, page 2 should be detached for use as th	Certification:	4 Homicide determined	building, etc. (Specify	)	ot, ractory, omoo		City or Town,		rai riodio rambol,
Division of Vital Recompline of Vital Recomplete or Attending Physicien: The laward for the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my known: On the basis of examination and manner stated.	vledge, death on and/or inv	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. License	e number	29	d. Date signed (Monti	n, Day, Year)
		1000	Their		0)	130	8	3/1 8/1-	7
_		30. Name and address of person who com WILLIAM ROBINS, M.	pleted cause of death (Item	23a) (Type, F <b>ΔVF</b>	Print)	V. MD 2	1804	<del></del>	
		31. Date filed (Month, Day, Year)				, 2.			
Regist	ate trar	MAR 2 9 2007	32 Registrar's Signati	Appa	the s				

Physician

/Medical

**Examiner** 

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Usual Residence of Decedent

228-42-8754

MD

11. Marital Status

10e. Street and Number

10a. State

Director

Funeral

<u>ک</u>

4a. Facility Name (If not institution, give street and number)

10b. County

646 North Fulton Avenue

1 Never Married 2 Married

3 ☐ Widowed 4 X Divorced

Wat

1 XM 2 □ F

Manyland Medical Center

12. Was Decedent Ever in U.S. Armed Forces?

1 ∵Yes 2 X No If Yes, Give Year or Dates:

7. Age (In vrs. last birthday)

72

10c. City. Town or Location

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anne. African American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer construction worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 646 North Fulton Avenue; Baltimore, Maryland 21217 Pauline D. Henson / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Western Star Cemetery 04/03/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disc se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final for a ted **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been si rector, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 500 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home ٩ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury Natural To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature State Registrar Becalle **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

10f. Zip Code

1 ☐ Yes 2X No

Days

Months

**Baltimore** 

4b. City, Town, or Location of Death

21217

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Lhimon

If Under 24 Hrs.

2. Date of Death

ar

8. Date of Birth (Month, Day, Year)

03/02/1935

27

12:53 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 □ No

2007

4c. County of Death

10g. Citizen of What Country?

14 Race - American Indian

Black, White, etc.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician DELORES** MARCH 22 WILLIAMS 2007 11:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3440 ASSOCIATED WAY #113 OWINGS MILLS BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/08/1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🕡 F 100-34-2582 63 Director NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3440 ASSOCIATED WAY #113 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo WHITE þ Specify: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER AVERY HARDWOOD FLOORS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If item 27 is marked off any lijuy or other traumatic ever once. SAMUEL EHRLICH FRANCES RICHMAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3440 ASSOCIATED WAY #113-OWINGS MILLS, MD 21117 THOMAS WILLIAMS/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buria 2 □ Cremation 3 Removal from State 5 ☐ Other (Specify) 4 🗆 Dg MARYLAND VETERANS 03/30/2007 | OWINGS MILLS, MD SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> art1. Enter the disease mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner dasta Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a a∏lJnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perform 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in ! 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month,

Day, Year)

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egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day  $A^{\,\text{M}}$ Paul A. Ashman March 2007 6:15 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9534 Angelina Circle Columbia Howard If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Director 213 10 4596 94 Sept 15, 1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ä la or 28a-f sho t be notified a 1 ☐Yes 2 TNo Directo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a items 23a 9534 Angelina Circle 21045 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 XWidowed 4 ☐ Divorced White 'natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Policeman Howard County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Ashman Justina Thomas 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Almas/Daughter 7027 Craddle Rock Farm Court Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State injury Metro Crematory 3-16-2007 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consec The law requires that the death certificate be executed Exami bunial-tran and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the SS IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy FOT in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an page 2 s has autopsy perform certificate 2X No 2 🔀 No 1[ Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) asst. Live 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 🔀 Natural Injury n 24 hours after death.

ne Funeral Director: A
bletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2. 12+1

Registrar

31. Date filed (Month, Day, Year) MAR 16

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29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

March 16, 2007

32. Projistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month G. W. Bunch March 9,2007 0315 M Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5150 Old Sudley Road River Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1<del>√</del> M 2□ F Months Days Hours Min. 429-38-7225 78 Director Apr.15,1928 Tulsa OK. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
Hygiene "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. MD Anne Arundel West River Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5150 Old Sudley Road 20778 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 □ No 49-61

If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Department of Defense Electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Bunch Sr. Lissie Stowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie E. Bunch Spouse 5150 Old Sudley Road West River MD 20778 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Maryland Veteran's 4 □ Donation 5 □ Other (Specify) March 15,06 Cheltenham, MD 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Aye Annapolis, MD 21401 21. Signature of Funeral S icensee 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardisi one Year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ž No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38563 March 9, 2007 untra w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rand, West River MD 20778 1340Wonsvilla Jierbaum 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 1 3 2007

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Physician Month 1Day 2007 Leroy Benjamin Bell March 07:05 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1400 Partridge Lane Bowie Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 08/18/1934 5. Social Security Number 6. Sex\_ 1 ☐ AM 2 ☐ F 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours Months Director Yrs 577-48-3243 Washington, D.C Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exaciting must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Bowie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1400 Partridge Lane 20721 United States Funeral . Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 🛣 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer G.P.O. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P Benjamin Bell Madge Siehl 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) <u>Jo Ann T. Bell/Wife</u> 1400 Partridge Lane, Bowie, Maryland 20721 20a. Method of Disposition Placa of Disposition (Neme of cemetery, crematory or other placa) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 3/15/07 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral 2973 Solomons Island Rd.,Edgewater, MD 21037 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Malignant Neoplasm Head, Neck, and Face Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) for usa as Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Parkinson's Disease δ within 24 hours after death.

To the Funeral Director: After this cartificate has been signs completely filled in by the funeral director, page 2 should be. Be Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D28079 03/12/2007 19 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Francine Higgs-Shipman, 9200 Basil Court, Suite 200, Upper Marlboro, MD 20774

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			1 For State	State of Mary					d Mental Hy	giene	7 7	10000
			Registrar  1. Decedent's Name (First, Middle, Last)		Ce	rtificate	of D	eath	2. Date of De	Reg. No.	) [	10022
	Physici		0		URP	BRY	0=	N	Month MARC	Day	Year	3. Time of Death
	/Medio Examin		4a, Facility Name (If not institution, give :				own, or L	ocation of D		4c. Count	of Death	21.204
			CHRSTER RIVER	e mand	2	CHE	STO	RIO	m	1<	en	1
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday, 94 Yrs.	If Under 1 Months		If Under 24 H Hours N	1 8. Date of Bir 1 0 4 0 6 7	th VOY gas)	9. Birthp Cour	olace (State or Foreign
	Director		Usual Residence of Decedent		94 fis.				04/00/.	1912		MD
	yland yland		10a. State 10b. County	10	c. City, Town or L	ocation					1	0d. Inside City Limits
	Ba-f si	ctor	MD KENT		ROCK	HALL						1 ☐ Yes 2 <b>]</b> ∑ No
	72 hours after death with the Maryland netural; or iteme 23a or 28a-1 show dical Examinar must be notified at	Funeral Director	10e. Street and Number 6017 BOYCE LANE			10f. Zip C	ode 216	61		10g. Citizen of USA	What Cour	ntry?
	Jeath ne 23	erai		12. Was Decedent Ever	in U.S. 13.	Was Deceder			(Specify Yes or No		e - Americ	can Indian
ထ္	after or item		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		If Yes, specify	7	Mexican, Pu Specify:	' (Specify Yes or No Jerto Rican, etc.)		ck, White, נונג	
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p	be file tai Hyi d othe	Be	17. Father's Name (First, Middle, Last) BENJAMIN FRANKLII	A EUDD			18		Name (First, Middle,		ne)	
Z Za	d Men narke	ို										
Maryland	Ith and 2 shall the and 27 is not traum		19a. Informant's Name/Relationship (Tyrical CANDY EDWARDS/GRA	•					Rural Route Number		State, Zip	Code)
ē,	is 1 ar		20a. Method of Disposition		Ob. Place of Dispo	osition (Name	of		Date	20c. Location	City or To	wn, State
<u><u>E</u></u>	Page ment c ant: If ury or	3	1 🖾 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State .	WESLEY C	HAPEL	CEME	TERY (	03/23/2007	ROCK F	IALL,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or iteme 23e or 28e-1 show any injury or other traumatic event, the Medical Examination and be notified at once.		21. Signature of Funeral Service License	Speker !	1 1	Name and ELLOWS	Address HE ER R	of Facility LFENBI OAD, (	EIN AND NE	WNAM FU	NERAI 21620	L HOME, PA
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the	death. Do not en	ter the mode	of dying,	such as card	diac or respiratory ar	rest,		Approximate Interval Between
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ı	/Medical Examiner		1 dealing in dealing	Due to (or as a co	nsequence of):							7
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8760,	cate be executed by sicien and the burial-transit	icai Examiner	resulting in death) cast	Due to (or as a cor	nsequence of):							
687	ficate physis the	adic	<b>~</b> d									
ŏ	h certi	In/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		75				23d. Da	te of delive	iry
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 gfonths? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	4☐Pregnant at time		Ectopic preg Other (spec				Mo	nth	Day Year
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ō	Phys r this ral dir	2	1 ☐ Yes 2 X No		2 ER/Outpatier				Home 5 Resid			)
O	Attending Physician: or death. ector: After this certifice by the funeral director.	atlon	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	Injury	M	. Injury at Work? 1 ☐ Yes	s 2 □ No	20d. Describe i	low injury occur	90	
Division of Vital Records,	or Attendi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, str	reet, factory, o	office		28f. Location (S City or Tow		er or Rura	l Route Number,
Ω	ours af ours af orai D											
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my ier: On the basis of exar and manner stated.	Knowledge, death mination and/or in	n occurred at vestigation, in	the time, my opini	date and pla ion, death o	ace, and due to the occurred at the time, o	ause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	10		29c. L	icense n	umber		29d. Date signe	d (Month, I	Day, Year)
	, ,		I Jun K	Slow	/nD.	M	d, -	0/20	36	3/2010	7	
	4		30. Name and address of person who cor		(Item 23a) (Type,	Print)	-0	01	estatom	1001	3//-	
ľ	n_s Sta	e.	31. Date filed (Month, Day, Year)	32. Registres S	ignature	tox 1 t	36	w	2 tr tom	rnd a	1142	0
	Registra		MAR 2		so de	Appen						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item, 5 per fh 8867 5-4-07 vt.

			1 - For State of Maryla		artment of Hea rtificate of De	ath	Reg	g. No.	10023
	Physici	an	1. Decedent's Name (First, Middle, Last) Helen Elizabeth Simms Burton				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)		th City Town and as	ation of Dooth	March 1		14:18 p M
	Examir	er	Chester River Hospital Center	r	4b. City, Town, or Local Chestertown			4c. County of Deat	n
-	Funeral			rs. last birthday)	If Under 1 Year If U		8. Date of Birth	Kent 9. Birt	nplace (State or Foreign untry)
	Director			72 Yrs.	Months Days Ho	ours Min.	8. Date of Birth (Month, Day, ) 11/20/1	934 <i>Co</i>	uintry) MD
	D		Usual Residence of Decedent           10a. State         10b. County         10c.	City, Town or Lo					
	sho	20	MD Kent	Rock I					10d. Inside City Limits 1
	28e-1	Director	10e. Street and Number	NOCK I	10f. Zip Code		100	g. Citizen of What Co	
	3a or	Ö	5706 Main Street		21661	1		SA	unity:
	death	Funerai	11. Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hispan	nic Origin? (Spec	of Yes or No-	14. Race - Ame	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I a marked other than "natural", or items 23s or 28e-f show aumatic event, the Medical Examiner must be notified at		Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuban, Mo 1 ☐ Yes 2 ☒ No Sp	exican, Puerto F Decify:	(ican, etc.)	Black, White Specify: Wh	
Ö	ural',	d by	3 ⊠ Widowed 4 □ Divorced Year or Dates:						
-5	in 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of workin	g 16	6b. Kind of Business/	ndustry
212	iene.	omp	Elementary/Secondary (0-12) College (1-4or 5+)		nemaker			Own Home	
פ	m - 0 2	Be C	17. Father's Name (First, Middle, Last)		18.	Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>Xa</u>	Menta Menta arked	ToE	Brant Oliver Simms, Sr.			Helen	Elizabet	th Gabler	
Jar	2 sho	. 4	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and N				ip Code)
a) a)	1 and 1 ealth 1 am 27		Sue Becker/PR  20a. Method of Disposition 20b		D. Box 166, sition (Name of	Rock Ha			
و	nt of h	1 8	1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crei	matory or other place)			ock Hall,	
Baltimore, Maryland 21215-0036	ntme		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee		2. Name and Address of	1	7/2007 K	ock naii,	MD
Ř	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic av pncs.		Jan Allen	Ì	Tellows, Hell 30 Speer Ro	lfenbein Dad. Che	and New	wnam Funer	al Home, PA O
	death certificate be executed  Medical  Exx  Medical  Exx  Moderne as the burial-transit  Mod	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Coupontiesly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consider of the conditions).	equence of):	tobrilla Asamyap Illation	tion 27hy			2 min
.O. Box 68	the death certifi by the attending ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	ital death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
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<u>r</u>	The lav	Con					performe	d? death?	2 00
711.9	ysician: Th	Be	25. Was case referred to medical examiner?			Place of Death	Check only one)		
5	Phys this aldi	<u>د</u>	1 ☐ Yes 2 SNo Hospital. 1 npatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatien				ce 6 □Other (Spec	ufy)
	Afte	ţ	1 ☐ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes		3d. Describe how	injury occurred	
DIVISION	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At	home, farm, str				et and Number or Ru	ral Route Number,
5	rs afte al Dir	Certification:	4 ☐ Homicide determined building, etc. (Spec	сигу)			City or Town, S	State)	
	To the Hospitel or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one).   Check one	nowledge, death	occurred at the time, da	ite and place, an	nd due to the caus	se(s) and manner as	stated.
	thin 2 thin 2 ths I	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License num				
	E.≱ ₹ 8							Date signed (Month	, Day, rear)
7	J		30. Name and address of person who completed cause of death /II/	am 23a) (Type	Print)	735		= 11710	au
	16		30. Name and address of person who completed cause of death (Itel PERSOY MD	602	OHURCH H	hu er	CHC	TELLOW	MD 21670
	Sta	te	31. Date filed (Month, Day, Year) 32. Registar's Signary 1 0 2007	nature	A. M.				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar/Amend#5.PerInformantPCC3-22-07cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joan Winifred Boyd 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Doctor's Community Hospital Lanham Prince George's 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🖾 F Days Hours Min. Mar 30, 74 1932 Alabama Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1KTYes 2∏No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12013 Millstream Drive 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Hancock Lillian Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael K. Boyd - Son 9104 7th Street, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Fort Lincoln Cemetery 3/20/2007 Brentwood, Maryland 21. Signatural Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Many Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed 2 1 1∐ Yes 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

law requires that the death certificate be executed burial-tra P.O. Box 68760, physician the ed by the a detached f Division or Vital Records, funeral director. this After

e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t filled in by the Physician/Medical Examiner

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Completed

Be

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Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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Department of Heal Important: If item 2 any injury or other once.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

To the Hospital of within 24 hours at To the Funeral D Medical State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 27. Manner of Death 5 ☐ Pending investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1535 ( 32. Registrar's Signatu 4.0 GREENWAY CENTER 680KGE 31. Date filed (Month.

29c. License number

MAR 18

29b. Signature and title of certifier

			1 For State	State of Mary		artment of F			2007	10025
			Registrar  1. Decedent's Name (First, Middle, Las	t)	00	tinicate or	Death	2. Date of Deat	ng. No. UU/	3. Time of Death
	Physici	an			<u>-</u>			Month	Day Yea	r
	/Medic		Joseph Berti  4a. Facility Name (If not institution, give	uiii		4b City Town o	r Location of Death	March	8 2007 4c. County of De	6:27P <sup>™</sup>
4	Examir	ier	Frederick Memoria						Frede	
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)		derick If Under 24 Hrs.	8. Date of Birth	9.8	irthplace (State or Foreign
	Funeral Director			ZIM SITE	73 Yrs.	Months Days	Hours Min.	Jan. 18	Year) 1934 Pe	Country) ennsylvania
			Usual Residence of Decedent		<u> </u>		1		,,,,,,,,,,,	
	ylanc		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar 9-f s	Director	Maryland Frede	rick	Nev	v Market				1 ☐ Yes 2 🛣 No
	h the	le le	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
	h wit	<u>=</u>	10150 Vantage	Point Court	•	217	74		U.S.A	١.
	within 72 hours after death with the Maryland ane. then "naturat", or items 23a or 28e-f show 's Madical Examinat hancilised at	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No-	14. Race - Ar Black, WI	nerican Indian,
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Maryland	12 should be filled within h and Mental Hygiene. 7 is marked other then "treumatic event, the Max		19a. Informant's Name/Relationship (7				and Number or Rura			
_	l and fealth im 27 her tr		Janet C. Bronder/		10150 Ob. Place of Dispo		Point Co			, MD 21774
0	Pages I nent of H ant: if its		20a. Method of Disposition 1 🖔 Burial 2 □ Cremation 3 □	Removal from State	cemetery, crea	matory or other plac	ce)		20c. Location - City	
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Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itsm 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Modical Examination must be notified at once.		21. Signature of Funeral Service Licer	\$00 / /n / /// / / / / / / / / / / / / /	/		ess of Facility Har			CONTRACT LINE
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that doused the one cause on each line.	death. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	1 7 25	nint	000 /	ティノン・	~		12 h
	/Medical Examiner		resulting in death)	Due to (or as a for	nsequence of):					
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Sio	Attending r death. ector: After by the fune	catl	2 Accident investigation			M 1 🗆	Yes 2 □ No			
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	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exam	/sician: To the best of my iner: On the basis of example.	/ knowledge, deat mination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
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		-	29b. Signature and title of certifier	7/		29c. Licens			d. Date signed (Mo.	
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			For State Registrar	State of I	Marylan		artment rtificate			and M	lental H		ene 1. No.2 0	07	10026
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	Funeral			5. Sex 7.		last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of E	Day, Y	(ear)	9. Birthp	place (State or Foreign
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	Ne M	ecto	DC 10e, Street and Number		Wa	shingt	on 10f. Zip	Code				100	g. Citizen of	What Cou	ntrv?
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	eath	era	11, Marital Status	12. Was Decede	nt Ever in U	.S. 13.	_			gin? (Spi	ecify Yes or Rican, etc.)		14. Ra	ce - Ameri	
	iter d	F	1 ☑ Never Married 2 ☐ Marrie	Armed Force	s?						Rican, etc.)			ack, White,	
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Maryland 21215-0036	12 sh h and 7 is n treun		19a. Informant's Name/Relationsh Darcel Anderson			471	0 Geor	gia	Ave.	, N.	W., Wa	ash	., D.(	200	011
ē,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-f show apprintury or other treumatic event, the Medical Examination at a police.		20a. Method of Disposition		20b. F	Place of Dispo	osition (Nan	ne of	al l	(	Date	20	Oc. Location	- City or T	own, State
Baltimore,	ages ent of it: If if		1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		10	emetery, cre Linc	-			3/15	/2007	F	Brentw	ood.	MD
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Ē		ü	27. Manner of Death  1 Satural 5 ☐ Pending		Day Year)	28b. Time o	M Z	8c. Injur Wor	yai k? Yes 2. ☐	INo	280. Descri	De HO	w wijury occu	uned	
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	To the Hospitel or Attanwithin 24 hours effer deall To the Funaral Director: completely filled in by the		(Check only 2 Medical 8	Physician: To the be examiner: On the base	s of examina	owledge, dea	th occurred	at the tir	ne, date ar	nd place, alh occur	and due to t	he ca	use(s) and n te and place	nanner as a, and due	stated. to the cause(s)
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	Z <u>≥ Z 8</u>							(		16	,7		31	17/	7
	170		30. Name and address of person v	who completed cause	of death (Ite	m 23a) (Type	. Print)		70	17		<u> </u>	/	1/6	
L	151		DR. NASRELI	J KANA	0	7610		11 A	Ve	Tako	ma Par	rk,	MD /20	0912	
1	Sta	ate	31. Date filed (Month, Day Year)	32. Reg	istrar's Sign	m 23a) (Type	•								
	Regist	rar	WAR 13 SAM	Deien	D. 1	The same									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar, AMEND#23a(II)perMD3/26/07, BMW, Moco Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:45 p March 7. 2007 /Medical Johnnie Mae Brown 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kensington Nursing and Rehabilitation Kensington
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth Jan. 3, 1920 5. Social Security Number Age (In yrs. last birthday) If Unde Hours Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 👿 F Director 411-26-1432 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of health and Mental Hyglene. Intent of health and Mental Hyglene. Int: If fem 27 is marked other than "hatural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Maryland | Montgomery Director Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 McComas Avenue Funeral 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? . Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Unknown Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Klein-Guardian 401 Hungerford Drive, 2nd Flr., Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Baltimore Crematory 3-16-2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute, 1040 Rockville 21. Signatur, of Fun ral Service Linensee Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, hading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISORDER SEIZURG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes 2 12 No 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of eath Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 4 100 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Tes 2 □ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY N. ROSENISAUM 3720 FARRAGUT AVE. KENSINGTON, MD. 20895 BARRY N. ROSENBAUM

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

15

2007

egistrar's Signature

			For State	State of Mary	land / Depa		ealth and M	lental Hyg	21111	7 10028
			Registrar  1. Decedent's Name (First, Middle, Last	2)			Journ	2. Date of Dea	teg. No."	3. Time of Death
282	Physici		AGNES	C	LARK			Month	10 200	ar
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of D	
1	Exami	ici ik.	Anne Arundel Medic			Annapoli			Anne Aru	ındel
A	Funeral		5. Social Security Number 6. Se	x / 7. Age (In	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country) Shington, DC	
	Director		579-28-4862	□M 2 <b>0</b> F	81 Yrs.	Months Days	Hours Min.	2/15/192	26 Was	shington, DC
	pu .		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	eho eho	5	, , , , , , , , , , , , , , , , , , , ,		•	cation				1 ☐ Yes 又又 No
	the M	ect	MD Anne Arun	ider A	nnapolis	10f. Zip Code			10g. Citizen of What	
	with a or	2	110 Hearn Rd #408			21401			USA	Country
	leath	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13. \		ispanic Origin? (Spe	ecify Yes or No-		American Indian,
10	riter	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No			ispanic Origin? (Spen, Mexican, Puerto	Rican, etc.)		Vhite, etc.
03(	al', o	<u>م</u> ا	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	•	1 ☐ Yes 2X No	Specify:		Specify:	White
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f ehow ha Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	ient's Usual Occupa	ation during most of worki	ina	16b. Kind of Busine	ess/Industry
2	ithin De.	jdr	Elementary/Secondary (0-12)	College (1-4or 5+)			)		0 11	
2	filed w Hygier Sthertt ent, th	S	12 17. Father's Name (First, Middle, Last)		Но	memaker	10 Markada Nasa	/Fi- A A 41-4-44	Own Home	3
and	be fi	Be					18. Mother's Name		Maiden Sumame)	
Ž	should nd Men rmarke urnatic	٩	Edward Ryan  19a. Informant's Name/Relationship (T)	voe Print)	10h Mailin				r, City or Town, Star	te Zin Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.		William Clark	Son		-	ne Belts			is, 21p 0006)
	Heel Heel tem		20a. Method of Disposition	2	0b. Place of Dispo	sition (Name of natory or other place	, [	Date	20c. Location - City	or Town, State
Baltimore,	Pages nent of int: If it		1 Burial 2 Femation 3 II 4 Donation 5 Other (Specify,	Removat from State	letro Cre			/2007 H	Baltimore	, MD
alti.	permit. Pa Departmer Important any injury 2002.		21. Signature of Funeral Service Lines						ineral Hor	
ñ	Depa Impo any ir		172-1.0	12			Ave. Anna			ac, 1
	<b>D</b>		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arr	rest,	Approximate Interval Between Onset and Death
k.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co	neadnance of):	-4 (	econ			mony
	Examiner				11304001130 01/.					
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760,	e exe	EX	resulting in death) Last	Due to (or as a co	nsequence of):					
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	ding p	Physician/Med	IF FEMALE:	220. If was outcome of or	20000000					
Box	attend for us	lan	in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 【 No 9 ☐ Unknown	9☐ Unknown	ordeath 5L	Other (specify)				
	signed by	y Ph	Part II. Other significant conditions co	ntnbuting to death but no	t resulting in the un	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
Records,	n sign	d by						1 🗆 Y	es 2 No 3	Probably 4 Unknown
00	s been si should	jete						24a. Was a	an 24b. Were	autopsy findings available
Re	The la	Completed						autop: perfor	med? deat	to completion of cause of h? Yes 2 ☐ No
Vital	an: rtitica tor, p	0	25. Was case referred to medical				26. Place of Death			165 2 100
<b>&gt;</b>	Physician: this certitic ral director,	To B	examiner? 1 ☐ Yes 2 B No	Hospital: 1 Nopatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 🗌 Nursing Ho	me 5 Resid	ence 6 Other (S	Specify)
0	ng Pt fter th	:uo	27. Manner of Death 1 Salatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye.	ar) 28b. Time of Injury	28c. Injury Work	at k?	28d. Describe h	ow injury occurred	
Sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of	or Ati	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, street, pecify)	eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	pital nurs a eraf [	S	200 Continue 1 A Continue Phys	raining. To the book of the						
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	rsician: To the best of my iner: On the basis of exa and manner stated.	mination and/or inv	estigation, in my of	ie, date and place, pinion, death occurr	ed at the time, o	ause(s) and manne late and place, and	due to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier	Λ		29c. License			29d. Date signed (M	
	⊢ s ⊢ ö		Maril & Ze	te ta	1	0	21438		Marin	L 11 2117
	1/		30. Name and address of person who c	ompleted cause of death	(ttem 23a) (Tvpa.	Print)	11		7	- 11,000/
	H		MICHAM J. Late	w m	445	EFENS	E NIGI	mm A	NAPOLIS	M 11, 2007
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature					,
***	Regist	rar	100.01 T 9 500	A Company	S. don	Al a				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	Marylan		artment o			lental Hy	giene Reg. No.	2007	100	30
	Physici	an	1. Decedent's Name (First, Middle, Last)						Year 200	3. Time of D				
	/Medic Examin		Theresa Ann Crow 4a. Facility Name (If not institution, give DORCHESTER GE	re street and num		TAL			ation of Death	MARCI	4c. (	4c. County of Death DORCHESTER		
4	Funeral Director			Sex 1 □ M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months C		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da July 1	th ly, Year)	9. Birth Col 936 Micl	nplace (State or i	Foreign
2-	pu *		Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo	ocation			Joury 1	·, <u>-</u> .	750 1110	10d. Inside City	Limits
Se	n 72 hours after deeth with the Maryland "natural", or items 23e or 28e-f ahow golical Examiliar navat be notified at	tor		Maryland Dorchester								1 □Yes 2 ⊡No		
4		Funeral Director	10e. Street and Number 3318 Landrum Driv				10f. Zip C				10g. Citiz	0g. Citizen of What Country?		
5		neral	11. Marital Status	12. Was Deced	dent Ever in U.	.S. 13.		21631 nt of Hispa		ecify Yes or No Rican, etc.)	)- 1	USA 14. Race - Ame		
Thersa 1215-0036	72 hours after deeth w "naturel", or items 23a adical Examinat must I	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes Sife Yes, Give Year or Da	2 <b>⊆</b> 1√√0 9		1 ☐ Yes 2 ☐	No SI	pecify:	Hicari, etc.)		Specify: W	White	
7	in 72 h n "natu Nedice	piete	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-	400 5 1)	16a. Dece (Give life.	dent's Usual ( kind of work of DO NOT use	Occupation done durin retired)	n ng most of work	king	16b. Kir	nd of Business/	ndustry	
N	led with lygiene her the	Be Completed	Elementary/Secondary (0-12)	2	401 5+)	Licen	sed Pr		al Nur		14-14		th Care	
e y land	id be fi Sental H Ked ott	To Be	17. Father's Name (First, Middle, Last)  Charles Johnson  18. Mother's Name (First, Middle, Maiden Sum Theresa Forsberg								Sumame)			
Crowley Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than any injury or other traumatic event. Its Misono.		19a. Informant's Name/Relationship (Sheila Crowley No		hter	1				anbridg			_	
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altir	ermit. P epartme oporten ny injur		4 Donation 5 Dother (Specify)  MD Veterans Cemetery 3/19/2007 Hurlock, MD  21. & nature of Funeral Service Licensee  Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613											
	205 2 9		23a Part 1. Enter the disease or con	polications that ca	ysed the deat	h. Do not en	08 Hig	h St.	Camb	ridge,	mD , z	21613	Approximate	
	Physician /Medical Examiner		shock, or heart failule. List only Immediate Cause (Final disease or condition resulting in death)	lure						Interval Betwee	eath			
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
687	rtificate ng phys													
Division of Vital Records, P.O. Box 6	Attanding Physician: The law requires that the death certific: r death. octor: After this certificate has been signed by the ettending pl by the funeral director, page 2 should be detached for use as t	Physician/Mec	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta int at time of d	Ideath 3	□Ectopic preg □ Other (spec				2	23d. Date of delivery Month Day Year		∍ar
rds, P	quires that in signed b uld be deta		Part II. Other significant conditions  Decripe ( ) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	contributing to de	ath but not res	ulting in the u	inderlying cau	se given in	Part I.		obacco us		the cause of dea	
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1 0	ding Physician: The I h. After this certificate ha funeral director, page	n: To	1 Yes 2 No  27. Manner of Death	Spir	patient 2 f Injury n, Day Year)	ER/Outpatier 28b. Time o Injury		: Injury at Work?	4 Nursing H	ome 5 Resi 28d. Describe			efy)	
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	To the Hospital or Attantwithin 24 hours effer death To the Funeral Director:	Medical Ce		hysician: To the la miner: On the ba and mann	sis of examina									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11 -			29c. l	icense nu	mber		29d. Date	e signed (Monti	n, Day, Year)	
			Muyem /	Jen- 2	20	- 024) (5	H	517	93		3/	15/07		
			30. Name and address of person who Evyrne Newmi	Fr D	0	503	By By	50	5+	Can	bria	be M	0 216	13
- 1	Sta Registr		31. Date filed (Month, Day Year)	5 2007 32. Re	attrar's Signa	iture	1	a.,			,			

			Please I	State of Mar				•	•	ie.		
			1 _ For State	State of Mai				nental Hyg	giene n	7 10031		
			Registrar		Ce	rtificate of	Death		leg. Nd	7 10001		
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	3. Time of Death		
	/Medic		LUCY			COLE		MARCH		.007 10:30P <sup>M</sup>		
	Examin	er	4a. Facility Name (If not institution, give s				or Location of Death		4c. County of			
			LARKIN CHASE NURS  5. Social Security Number 6. Sex		BILITATIO (In yrs. last birthday)		OWIE	8. Date of Birth		ICE GEORGES		
	Funeral Director		1	M 2∭F	88 Yrs.	Months Days		(Month, Day	, Year) 1010	9. Birthplace (State or Foreign Country)  DC		
			578-30-2461 Usual Residence of Decedent		00			00-10-	1910	DG		
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	a-f s	ctor	MD PRINCE G	EORGES	BOWIE					1 □ Yes 2 No		
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh			
	72 hours after death with the Maryland Insturel; or Items 23a or 28a-f show Jical Exacilists quatibe notified at		15005 HEALTH CENT	ER DRIVE		1	716			USA		
	after dea or Items	Funeral		12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, White, etc.		
5	ours after dearer ref., or Items	by Fi	1 ☐ Never Married 2 ☐ Married  3XXWidowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes ŽŽNo	Specify:		Specify:	BLACK		
212-0036	72 hours 'neturel', dical Ex	ed t	15. Decedent's Educ		16a Dece	dent's Usual Occu	ination		16b. Kind of Bus	iness/Industry		
Ò	iin 72 ho n "netur	plet	(Specify only highest grade	e completed)	(Give	kind of work done DO NOT use retire	e during most of work ed)	ing		,		
7	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ERIA SER	VICES		PH	ENTAGON		
and	be filed ttal Hygi ed other event, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame,	)		
07		S E	RICHARD TOLIVER				SHIR	LEY HALE	ΣY			
<u>a</u>	d 2 should th and Mer ?7 Is marke treumatic	Ė	19a. Informant's Name/Relationship (Type	· . ·			et and Number or Run					
≥	s 1 and 2 if Health item 27 other tr		CYNTHIA C. THOMAS	/DAUGHTER						), MD 20774		
ore	of H of H if ite		20a. Method of Disposition  **Burial 2	emoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location - C	ity or Town, State		
	Pa in the last		`4 □ Donation 5 □ Other (Specify)		MARYLAND			0-2007		IL, MD		
saitimore	permit. Departr Importe eny inju		21. Signature of Fune al/Service License			2. Name and Addr MARSHALL	ess of Facility S FUNERAI	HOME O	F MARYLA	ND, INC.		
			23a. P. 1. Enter the disease, or compli	cations that caused the			TLAND ROAL		LAND, MI	Approximate		
			sock, or heart failure. List only or Immediate Cause (Final	ne cause on each line						Interval Between Onset and Death		
1	Physician /Medical		disease or condition resulting in death)		PIRATORY consequence of):	FAILURE						
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l.		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):	IEAKI FAL	LUKE					
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events									
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2/00	ate be hysici ihe bu	llcal		J								
200	leath certificate b attending physicate to a sthe b	Physiclan/Medl	IF FEMALE:	2- 16								
X O D	death c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnanc	су		23d. Date Mont			
o.	0 0 2	ysic	1 ☐ Yes 24☐No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	ille oi deatii 3 (	Other (specify)						
ŗ.	requires that the een signed by th hould be detache		Part II. Other significant conditions con	tributing to death but	not resulting in the u	inderlying cause g	iven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?		
gs,	juires tha n signed ald be det	d by	ATRIAL FIBRILLATI	ON				1 □ Y	es 2 🛚 No 3	Probably 4 Unknown		
cord	> 0 0	lete	FAILURE TO THRIVE					24a. Was a	an 24b. W	ere autopsy findings available or to completion of cause of		
Č	9 4 9	Completed						autop: perfor	mad?   de	or to completion of cause of ath? ]Yes 2 [] No		
VII	icien: Th certificate rector, pag	O	GENERAL DEBILITY 25. Was case referred to medical				26. Place of Deat			1103 20 110		
	1 <b>88</b>	To B	examiner? 1 ☐ Yes XXNo	fospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA	ther: 4XXJursing Ho	ome 5 🗆 Resid	ence 6 Other	(Specify)		
0 0	ding Ph h. After th funeral		27. Manner of Death  1XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of 28c. Inju	ury at ork?	28d. Describe h	ow injury occurred			
20	Attending ir death. ector: After by the fune	catle	2 ☐ Accident investigation				Yes 2 No					
DIVISION	I or Attendater death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st ( <i>Specify</i> )	reet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,		
	Hospitel of hours a Funerel C		29a. Certifier XX Certifying Phys	rigina, To the best of	mu knowlodae does	th annual at the t	lime, data and alaca	and due to the	auca(c) and man	nor as stated		
	Hos Fur	edical		sician: To the best of ner: On the basis of e and manner state	xamination and/or in	ivestigation, in my	opinion, death occur	red at the time, o	late and place, ar	d due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	ise number	2	29d. Date signed	(Month, Day, Year)		
				In .	Ms		0045217		3/14/2	2007		
	(6)		30. Name and address of person who	mpleted se of dea	ith (Item 23a) (Type,	Print)						
	9		ADEBOWALE AJAYI,	6201 GREEN	BELT RD,	COLLEGE	PARK, MD	20740				
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 2007	32. Registrar	s Signature.	•						
			,,,,,,,		- 4							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Catherine Mary Chase March 11020AM ,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 79 212-24-4521 Director 4/3/27 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Md. P.G. Springdale 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3505 Saint Johns Place 20774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: African-American 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed ♣ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) Statistician Bureau of the Census 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph T. Hawkins Olive Spencer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Chase Harris-Hughes/Daughter 124 West Way # 202, Greenbelt, Md. 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cem. 3/20/07 Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Dal any 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CUTE -EU ICEMIA WITH BLAGTIC Physician /Medical Due to (or as a consequence of): Examiner ZAUDBOUF SEPSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner SEVENE The law requires that the death certificate be executed Ithron go CT TOP (me I A and Due to (or as a consequence of): aftending physician for use as the buria ABDUM, MAR Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ MYELODYSPLASIC SYMARAME 1 Yes 2 No 3 Probably 4 Conknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Maryl

Itimore,

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) **MAR 1 6 2007** State Registrar

29b. Signature and title of certifier

AZEEZ

8118 ABIODUM 32. Registrar's Signature

PHTSICIAM

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

GOODLUCK

D 67 810

RO

29d. Date signed (Month, Day, Year)

L PAHMA M

07

State of Maryland / Department of Health and Mental Hygiene, 10033 Certificate of Death Reg No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 9:05 A. M **Physician** March 8, Mattie Louise Martin Clarke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Cheverly Prince Georges Hospital Center 8. Date of Birth (Month, Day, Year) April 6,1914 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours **Funeral** Months 1 ☐ M 2 🛣 F North Carolina 92 579-34-2130 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location the Maryland 10b. County 10a. State 28a-f ahow the Medical Examiner must be notified at 1X Yes 2 No Director District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number N. E. tema 23a or United States 5000 Nannie Helen Burroughs Avenue 20019 Funerai death 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2**X** No If Yes, Give filed within 72 hours after 5 Specify: Black 1 Yes 2X No Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) then Domestic Domestic Worker 6th grade avant, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fit iment of Health and Mental Hiant: If Item 27 Is marked off jury or other traumatic avan Alice. Woods (UNKNOWN) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print)
Thomas Joel Clarke (Husband) &
James Kearford Clarke (Nephew) 12802 Pine Tree Lane; Fort Washington, Maryland 20744 March 14, 2007 Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Mount Olivet Cemetery Washington, D. C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
R. N. Horton 2 Signature of Juneral Se N. Horton Company Morticians, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. randis 600 Kennedy Street, N.W.; Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Myocardial Infarction **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Arteriosclerotic Cardiovascular Disease The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Peripheral Vascular Disease Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No ō 4□Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Nunknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2XI No certificate Division of Vital Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the i Diractor 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Thomicide hours after thin 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785 M.D.,
32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Teresita Curry March 10, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Oct. 24, Birthplace (State or Foreign Country) Guam 7. Age (In vrs. last birthday) Months Hours Days 1 □ M 2 🖺 F 66 586-01-4032 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland 1 ☐ Yes 2 KNNo Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9711 Lemocks Drive 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1□Yes 2∰No Specify Specify: 3 ☐ Widowed 4 🙀 Divorced Asian 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vicente Salas Delfina Cruz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James D. Curry / Former Spouse 45643 Linden Lane Lexington Park, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) : 03/17/2007 Clinton, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Enter the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic encephalo disease or condition resulting in death) Unknown Due to (or as a consequence of Coron 916 Unknown Sequentially list conditions, if any, learning to infinitionate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2XX No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performe 1∐ Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

6

Items 23a

"natural", or

Is marked other

es 1 and 2 should be fil of Health and Mental H f item 27 Is marked oth

Pages 1 permit. Pages 1 Department of H Important: If ite any Injury or ot

filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified

Director

Funeral

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Completed

Be

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and burialattending physician the as use ò the detached ģ has

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed this certificate Be မှ After Certification: within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu Medical

25. Was case referred to medical examiner? Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🏋 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician:

State

29b. Signature and title of certifier

29c. License number 1)43446 29d. Date signed (Month, Day, Year)

3,10.07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Ave Snit 3-41 Silver spring

ROINTAN FARAHIFAR M.D

Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 3 2007

Charles Aloysius Curtis, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2007 10035 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificat	te of L	Death		, 0	Reg.	No.		
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)					l M	ate of Death lonth Darch 21, 20	av Year	3. Time of Death 1432 hrs	
		4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital			. City, Town, o Clinton	r Location o	f Death		4c. County of Prince G		
Funeral Director		215-70-1260 1XM 2_F 48	n yrs last birthd	lay) Yrs.	If Under 1 Yes Months Day		Mun	Date of Birth(N		Birthplace (State or Foreign Country) MARYLAN	4D
Aaryland 28a-f show any 1 nt once.	tor	MARYLAND PRINCE GEORGES	c. City, Town or							10d. Inside City Lim 1 XYes 2	
h the Mary 3a or 28a- otifi d it	Director	8208 BELLEFONTE LANE, APT. #	2		10f. Zip Code <b>207</b>	35			Citizen of Wha	,	
hours after death wit natural", or items 2 Examiner must be n	ed by Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  3 Widowed 4 XDivorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade comple	. No ted) 16a. De	If Yes	Decedent of Hi, specify Cuba es 2 X No Usual Occupation of working life	n, Mexican, specify:	Puerto Rical	n, etc.)	14 Race - White, Specify:	BLACK	
54 3 🗐	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  11TH GRADE	UP	HOLS	TERER		·		AUTOMO	TIVE	
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	æ	17. Father's Name (First, Middle, Last)  CHARLES ALOYSIUS CURTIS, SR.						t, Middle, Maid .H SMTT	den Surname) H SHADI	3	
	T <sub>0</sub>	19a. Informant's Name/Relationship (Type, Print )  KIZZY C. BROWN / DAUGHTER								, State, Zip Code) SINIA 22192	
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		21 I nature of F eral Free Li e	20b. Place of E crematory GIBBONS C	HURCE 22. Nar	place)  I CEMETE  ne and Addres	RY ]	THORNT	7,2007 E	RANDYW ERAL HO	City or Town, State  INE, MARYLAND  ME, P.A.	
Physician	1	Livia C. Information Johnson M  23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line		3439	<b>LIATN</b>	<u>GSTON</u>	ROAD,	INDLA	N HEAD.	MARYLAND 20	val
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Due to (or as a consequence)		lerot	ic cardi	ovascu	lar			Death	
cuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen									
exe al -	ledical	X UNPENDED AMENDED 27, peri	ME, g866,	4/2/	'07 TT						
Box 68760, earth certificate be he attending physicied for use as the burned for use as	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown									elivery D <b>ay</b> Year	
P.O. E es that the digned by the detached	ρ	Part II. Other significant conditions contributing to death but	t not resulting in	n the und	lerlying cause	given in Par	t I.			ute to the cause of death?  Probably 4  Unknown	n
cords, law requir has been s	Completed						_	24a. Was an autopsy performed Yes 2	pri ₫? de	ere autopsy findings availation to completion of cause diath?  Yes 2 No	
Vital Re- hysician: The this certificate	æ	25 Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ✔ ER/Outp	patient :		Othor -	Check anly o	-	sidence 6	Other:	
ion of V tending Ph eath or: After th	tion: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Tin	ne of Inju		ury at Work?		Describe how	injury occurre	d	
Division Hospital or Atta 24 hours after des Funeral Director tely filled in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	- At home, farm	n, street,	factory, office	building, etc		Location (Street or Town, State		or Rural Route Number, C	ity
To the Hos within 24 h To the Fun completely	edical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examinar and manner stated									
3 6 8	Me	29b. Signature and title of certifier  American Advisor Continue and C			29c. Licen	se number			d. Date signed	1 (Month, Day, Year) 007	
IR		30. Nane and address of person who completed cause of death Pamela E. Southall, MD Assistant Medical		111	Penn Stree	et, Baltim	ore, MD 2	21201			
St	ate	31. Date filed (Month, Day, Year) 32. Fegistrar's S	ignature	Lane	<i>K</i> ,				-		

			1 - For State Registrar	State of M	laryland / Do	epartment Certificate			and M		giene Reg. No. 0	07	10036
ì	Physici		1. Decedent's Name (First, Middle, L	ast)		C	ook			Month March	Day	Year 2007	3. Time of Death 15:00 P M
	/Medio Examir		4a. Facility Name (Il not institution, g The Johns Hopk	ins Hosp	pital .		(fime	re_	Ci	ty	No	4c. County of Death None	
7	Funeral Director		5. Social Security Number 446 40 5523 6.	4371 11 00 5	ge (In yrs. last birth 66 Yı	Months	1 Year Days	Hours	Min	8. Date of Birth (Month, Day Dec 14	, 1940	9. Birthr Cour OK I	place (State or Foreign ntry) anoma
	פ	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								1	10d. Inside City Limits 1 ☐ Yes 2 🏧 No	
	or 28a-	lrect	MD Howard  10e. Street and Number	<u> </u>	Columb	10f. Zip	Code				10g. Citizen of	What Cour	ntry?
	23a c	ralD	5421 White Mane				2104				Unite		
920	be filed within 72 hours after death with the Maryland hat Hygiene. ed other than "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	?  No	13. Was Deced If Yes, spec 1 ☐ Yes 2		panic Orig , Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: White		
21215-0036	within 72 he ene. than "natur na Medical	Completed	15. Decedent's (Specify only highest g	Education rade completed)  College (1-4or	5+)	Decedent's Usua Give kind of wor ife. DO NOT us Librari	k done du e retired)	ion i <i>ri</i> ng most	t of workir	ng	16b. Kind of		overment
	Hygie other	0	17. Father's Name (First, Middle, Las		1	LILDLALL	1	18. Mothe	r's Name	(First, Middle,			VELINGITE
Maryland	should be filed within tod Mental Hygiene. s marked other then umatic event, tra Me	ToB	Thomas Cook							e Hartn			
Mar	d 2 s th ar 7 is trau		19a. Informant's Name/Relationship Jonathan Cook/Bro			Mailing Address 1 White					-	n, State, Zip	o Code)
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer important: if item 27 is marke any injury or other traumatic ADGS.		20a. Method of Disposition 1 □ Burial 2√□ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from State	20b. Place of Cometery,	Disposition (Name of the Cremator)	ne of ther place,	)	D	ate	20c. Location		
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lic		M01044	22. Name and	d Address	of Facility	y Har	ry H. V	Vitzke'	s Fam	ily FH Inc. MD 21043
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ple org	an fai	of dying.		cardiac o	r respiratory ar	rest,	- 1	Approximate Interval Between Onset and Death WEEK
	/Medical Examiner		Due to (or as a consequence of):  Acute well ord leukewid  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									1 year	
8760,	cate be executed physician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. chroni	s a consequence of gastr s a consequence of	oratest	inal	Ы	eedi	ng			4 months
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 ☐Ectopic pro						ate of deliver	ery Day Year
	requires that been signed b should be deta	ρ	Part II. Other significant conditions	contributing to death	but not resulting in t	he underlying ca	ause giver	n in Part I.		23e. Did to	~		he cause of death?
Il Records,	: The law requirate has been page 2 should	Completed								24a. Was a autop perfor 1 Yes	sy	. Were auto prior to co death? 1  Yes	opsy findings available impletion of cause of 200 No
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: V.	_		Other	~		(Check only or			
of	iding Physician: The th.  After this certificate hy funeral director, page	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inj (Month, D	ury 28b. Tir		Bc. Injury a	4 🗀 Nu	2	ne 5 Resid 28d. Describe h			(y)
Division	al or Atter s after dea l Director id in by the	Certification:	3 Suicide 6 Could not determine	d 28e. Place of in	njury - At home, farn atc. (Specity)	n, street, factory	, office		2	28f. Location (S City or Tow		ber or Rura	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		Physician: To the bes aminer: On the basis and manner s	of examination and/								
)		ž	29b. Signature and title of certifier	, M	edical I	milar	Re s	_	000		March	ed (Month,	Day, Year)
	E.G.		30. Name and address of person who Ting Bao, 40		death (Item 23a) (T		fimor	e,	MI	) 2/2	3		
35.	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6	2007 32. Fingist	trar's Signature	Local	9						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physicia /Medica Examine **Funeral Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

State of Maryland / Department of Health and Mental Hygiene

	1- State Registrar Cert	ificate of Death	Reg. No.	7 10037
ian	1. Decedent's Name (First, Middle, Last)		Date of Death     Month Day Year	3. Time of Death
cal -	EARL WILLIAM CLINE		March 24, 2007	6:40 A M
ner	An English Name (If not institution of notice)	4b. City, Town, or Location of Death	4c. County of De	
e.E.	FREDERICK MEMORIAL HOSPITAL	FREDERICK	FREDE	RICK
	1⊠M 2□F Vrs	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9. Bi (Month, Day, Year)	rthplace (State or Foreign Country)
	2 1 7 - 1 2 - 1 3 5 9   8 5   Yrs.   Usual Residence of Decedent		3/6/1922	M D
	10a. State 10b. County 10c. City, Town or Loca	tion		10d, Inside City Limits
호	MD Frederick Fred	erick		1 ∑Yes 2 □ No
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
Ö	। ७। 905 Seminol Road			ountry:
nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	2 1 7 0 1 as Decedent of Hispanic Origin? (Spec	USA cify Yes or No- 14. Race - Am	erican Indian
Ξ	Armed Forces? If \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	as Decedent of Hispanic Origin? (Spe /es, specify Cuban, Mexican, Puerto F	Rican, etc.) Black, Wh	
þ	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 9 3 □ Widowed 4 □ Divorced Year or Dates: ₩ ₩ ☐ I	Yes 21 No Specify:	Specify:	<i>l</i> hite
Completed by Funeral	15. Decedent's Education 16a. Deceden	nt's Usual Occupation	16h Kind of Business	
e d	(Specify only highest grade completed)  (Give kii life. DC  Elementary/Secondary (0-12)  College (1-4or 5+)	nd of work done during most of working NOT use retired)	g	ŕ
ĕ	Sagne:	r Sewing Compan	v Shinnin	g Supervsr
Bec	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	5 Dapervar
일	William P. Cline	Stella	Heffner	
_		Address (Street and Number or Rural		Zip Code)
	Mary E. Cline 905	Seminol Road Fi	rederick MD 2	1701
	20a. Method of Disposition 20b. Place of Disposit	on (Name of Date of tory or other place)	ate 20c. Location - City o	r Town, State
	123 Buriar 2   Cremation 3   Hemoval from State	' ' '	/2007 B 2	
		Lvet Cem. 3/27/	200/  Frederic	k, MD
	ph ( Man M01176 10	Name and Address of Facility Kee	ney & Bastord	P.A. F.H.
7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter or heart failure. List only one cause on e.ch line.	6 East Church the mode of dying, such as cardiac or	St. Frederick, respiratory arrest.	MD 21/01 Approximate
	Immediate Cause (Final	0 Ta 1		Interval Between Onset and Death
	disease or condition resulting in death)  a	u failui		
	Mota bolec	widain.		
ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).	,		
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events	el failure midosis. testinal blu	d	
Exa	resulting in death) Last			
Medical Examiner	<u>a</u>			
ledi				
Į.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	A!-	23d. Date of de	elivery
icia	in the past 12 months?    I □ Yes 2 □ No	ctopic pregnancy ther (specify)	Month	Day Year
hys	9 Unknown			
γP	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
Completed by Physician/	Chimic lung disease	2	1 ☐ Yes 2 ☐ No 3 ☐ P	robably 4 Unknown
Set	Chimic lung disease		24a. Was an 24b. Were a	utopsy findings available
mo.	duo di		autopsy prior to performed death?	completion of cause of
Ö	25. Was case referred to medical	00 Plane of Parth	1 Yes 2 No 1 Yes	s 2 No
o Be	examiner?  Hospital: 1 Impatient 2 ER/Outpatient	26. Place of Death		
	27. Manner of Death 28a. Date of Injury 28b. Time of	- University Home	e 5 Residence 6 Other (Spe	ecity)
tio	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	and the state of t	
lica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street		f. Location (Street and Number or R	ural Route Number
erti	4 ☐ Homicide determined building, etc. (Specify)		City or Town, State)	ara risato rampor,
alc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	ccurred at the time, date and place, as	nd due to the cause(s) and manner a	s stated.
Medical Certification: To	(Check only 2 Medical Examiner: On the basis of examination and/or invesore) and manner stated.	tigation, in my opinion, death occurre	d at the time, date and place, and du	e to the cause(s)
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
	Jew MID.	MOD 00546	3/ 3/24/2	7
1	30. Name and address of person who completed cause of death (Item 23a) (Type, Prince 23a)		10 40.710	
		Ave Frederick	, MD 21701	

THI

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, 🖘

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

> State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** ARRISON Orear 2230 /Medicat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center **Annapolis** Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M-M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 212-30-5861 79 Dec 20 1927 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Severna Park 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Whites Rd. 21146 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married Married 2 💢 No Maryland 21215-0036 1 ☐ Yes 2☐XNo Specify. Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. nt: If item 27 is marked other than "nry or other traumatic event, the Mediry or other traumatic event, the Medi Elementary/Secondary (0-12) College (1-4or 5+) 10th n <u>Delivery</u> Fue1 Oi1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Harrison Day Mary Jane Pack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Day(Wife) 15 Whites Rd. Severna Park, Md. Baltimore, 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If itel any injury or oth 2Abs Place of Disposition (Manual C.) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Church Cemetery 3-16-07 Severna Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses WinName Rockets of Eacil Bons Mortuary, 821 West St. Annapolis, Md. 21401 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 moth disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen ( 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 After this certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

EXENSE HIGHWAY ANNAPAIS MOZIYO,

0

ENTA

32. Registrar's Signature

completed

cause of death (Item 23a) (Type, Print)

Name and address of person who

MAR 1 4 2007

MICHAR

31. Date filed (Month, Day, Year)

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Casey House

5. Social Security Number

315-01-3811 Usual Residence of Decedent

James J. Dalton

1**X**M 2□ F

4a. Facility Name (If not institution, give street and number)

	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	or	10a. State Wash, DC	10b. County None			own or Loca	i, D.C.						side City	
	the M	Director	10e. Street and Nur	mher				10f. Zip Code			100	. Citizen of What	Country?		
	3a or	I Dir			e Avenue #4	.09			0037		109.	USA	Country:		
	ms 2	Funeral	11. Marital Status		12. Was Decedent Ev		13. Wa			Origin? (Specify 'can, Puerto Ricar	Yes or No-	14. Race - A		dian,	
Q	or ite		1 Never Marr	ied 2 ☐ Married	Armed Forces? 1 Types 2 □ No If Yes, Give			Yes 2 XiNo			1, etc.)	Specify: W	hite, etc.		
3	ural",	d by	3 XWidowed	4 ☐ Divorced	Year or Dates: W	MTT				.,,.					
<u>۲</u>	"natı	lete	(Spec	15. Decedent's Ed	lucation de completed)		(Give kii	nt's Usual Occ and of work don NOT use retir	e during m	nost of working	16	b. Kind of Busine	ess/Industry	/	
717	withii iene. r than	Completed	Elementary/Seco 12	indary (0-12)	College (1-4or 5+ <b>5+</b>	)   E		n Servi	•	ficer	US	S State	Depar	tmen	t
Maryland 21215-0036	0 = 0 \$	Be C	17. Father's Name						18. Mot	ther's Name (Firs		iden Surname)			
<u>Ja</u>	should be find Mental I	To	Willia	m R. Dalt	on				Hor	noria Mc	Kenzie				
lar.	2 ar ar			ame/Relationship (		- 1				nber or Rural Ro		-		e)	
	s 1 and if Health Item 27 other to	2.3	Mala Ual  20a. Method of Disp		dore/Daught					Rd. Alex		, VA ZZ3 c. Location - City		Ptoto	
و	0 0		1 🗌 Burial 2	Cremation 3	Removal from State			ion (Name of tory or other p	1	3/10/0	_	·			
Baltimore,			4∐Donation  21. Signature of Fu	5 ☐ Other (Specify		Cren	22 1	Center	ress of Fac	i		Chantill	.y, V	4	
ğ	permit. Departr Importa any Init			in part	1	line.		Mur	phy E	Tuneral Blvd. A	Home	~~ T7A	22203	)	
					plications that caused to one cause on each line	he death.	Do not enter	the mode of d	ring, such	as cardiac or res	piratory arrest	JII, VA	App	roximate rval Betwe	een
	Physician		Immediate Cause (	Final	a. Metastat								Ons	et and De	ath
**	/Medical		resulting in death)		Due to (or as a			Cancer							
	Examiner	_	Sequentially list co	nditions,	b										
	ted 1sit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	nmediate erlying iniurv	Due to (or as a	consequer	ice ot):								
	execution and al-tran	xan	that initiated events resulting in death) I	Last	cDue to (or as a	consequer	nce of):						+		
9	e be (siciar			•	d										
BOX 68/6U,	rtificat ng ph) as th	<b>fedi</b>	IE EEN NE												
Š N	ath ce ttendii or use	an/l	IF FEMALE: 23b. Was deceden		23c. if yes, outcome p 1 ☐ Live birth 2	Fetal de	eath 3 □E	ctopic pregnar				23d. Date of Month	delivery Day	Ye	ear
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical	in the past 12 1 ☐ Yes 24 9 ☐ Unknown		4□Pregnant at ti 9□Unknown	ime of deat	th 5□0	ther (specify)				World	Day	10	ui .
ў. Э	that the post of t	/ Ph	Part II. Other signi	ficant conditions of	ontributing to death but	not resultin	ng in the und	erlying cause g	iven in Par	rt I,	23e. Did tobac	cco use contribut	e to the ca	use of dea	ath?
Hecords,	quires n sign	q pe	G	astric Ly	mphoma						1 ☐ Yes	2 X No 3 □	] Probably	4 □Un	known
ပ္က		plete	F	rostate (	Cancer						24a. Was an	24b. Were	autopsy f	indings av	/ailable
ă a	in: The law i ificate has be or, page 2 sh	Completed									autopsy performe 1□ Yes 2 •	d? deat I-No 1□	h?		ise of
VITA	cian; ertifica	Be	25. Was case refer examiner?	red to medical						ace of Death (Ch	eck only one)	<u> </u>			
5	Physician; this certific ral director,	으	1 Yes 2		Hospital: 1 ☐ Inpatien  28a. Date of Injury		VOutpatient	3 DON		Nursing Home			Specify) H	ospic	e
DIVISION OF	ding h. After funer	tion:	27. Manner of Deat 1√2Natural	5 □ Pending investigation	(Month, Day	Year)	injury	28c. Inj W	uryaτ ork? ⊒Yes 2∣		Describe now	injury occurred			
	e Hospital or Attending Physician: 24 hours after death E Funeral Director: After this certific letely filled in by the funeral director,	Certification:	2 ☐ Accident 3 ☐ Suicide	6 Could not be determined	28e. Place of injur		e, farm, stree			28f. L	ocation (Stree	et and Number o	r Rural Rou	ite Numbe	e <i>r</i> ,
5	al or s after	Serti	4  Homicide		building, etc.	(Specify)					City or Town, S	State)			
	lospit hour unera	cal (	29a. Certifier (Check only		ysician: To the best of niner: On the basis of										
	후 등 혹 등	Medical	one)		and manner state				se numbe						
	To with	2	29b. Signature and		m mill	lem	a D			3032	- 1	. Date signed (M 3 - 7.			
	(20)								UJE	3032			acr	7	
L	(40)		Cynthia M	1. Williar	ns, DO Montg	omer\	HOSD	ice 600	1 Mur	ncaster	Mill R	d.Rockvi	lle,	MD 2	:0855
	Sta	te	31. Date filed (Mon	th, Day, Year)	32. Registrar	's Signatur	P 2								
	Registr	ar	MAR 1	3 2007	Bren D.	19									
DHI	MH 17 Rev 1/2	001				7.	ORIG	INIAI							
							ONIG	IINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

Rockville

7. Age (In yrs. last birthday)

88

Yrs.

2. Date of Death Month

8. Date of Birth (Month, Day, Year) 7/4/18

March

2007

9. Birthplace (State or Foreign Country) Indiana

4c. County of Death

Montgomery

			T = For Stete Registra@MFND#	70erFH3/1!	State of Ma			artmen <i>rtificat</i> (					giene (	<b>9</b>	7	1001	+0
	Physici		1. Decedent's Name (First		-17-27-2		nlap					2. Date of Dea Month March		200	aar a	3. Time of Do	
	/Medic Examin	18	4a. Facility Name (If not in	institution, give s	treet and number)			4b. City,	Town, or	Location of	of Death			ounty of		_	
45	,		Friends	House				Sa	ndy	Spr	ing		M	ont	gom	ery	
	. Funeral		5. Social Security Number	f 6. Sex	7. Ag		. last birthday) 93 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. I	B. Date of Birt (Month, Day 8/26/	h y, Year)		Count		-oreign
l.	Director		260-60-25 Usual Residence of Dece	00 -		75	JJ Yrs.					8/26/	1913	3	Geo	rgia	
	land ow			County		10c. C	ity, Town or Lo	cation							10	Od. Inside City	Limits
	Many Fed	ō	Md M	ontgom	ery		Sandy	Spri	.ng							1 Tes 2	No.
	or 28g	Director	10e. Street and Number					10f. Zip	Code			T	10g. Citize	n of Wh	at Coun	try?	
	23£ c	aiD	17401 Qua	ker La	ne			2	0860	0				U	SA		
	tams	by Funerai	11. Marital Status		<ol><li>Was Decedent Armed Forces?</li></ol>		4	Was Deced	lent of His	spanic Ori n, Mexicar	gin? (Spec n, Puerto R	ity Yes or No- ican, etc.)	- 14		America White, e	an Indian, etc.	
36	s afte	y Fi	1 Never Married 2		1 Yes 2 1	w19.	37-	1 ☐ Yes	2 <b>∏</b> No	Specify:			S	pecify:	Wh:	ite	
21215-0036	72 hours after death with the Maryland 'natural', or itams 23c or 28a-f ahow dical Extraller must be notified at			Decedent's Educ	Year or Dates: ation	190	-	dent's Usua	al Occupa	tion			16b. Kind	of Busi	ness/Ind	ustry	
215	within 72 ene. than *na	plet		ly highest grade		5.4.)	(Give	kind of wor DO NOT us	rk done di se retired)	uring mos						,	
	filed with Hygiene other the	Completed	Liomontary, cocondary	(0 /2)	4		Mi]	litar								e Corp	)
Maryland	S should be filed within and Mental Hygiene. Is marked other than sumatic avant, I.a.M.	To Be	17. Father's Name (First,  Claud Ev		nlap							First, Middle, level		,		11	
Mary	ロモトン		19a. Informant's Name/F			Dau						Route Numbe				Code <b>3970</b> s,MS.	)1
ē,	s 1 and 2 f Health a item 27 li		20a. Method of Disposition			20b.	Place of Dispo cemetery, crei	sition (Nan	ne of		Da		20c. Loca				
E	Page lent o nt: If ry or		1 ☐ Burial 2 🕵 Cre		moval from State		hesape	-			/14/	07	Bel	tsv	ille	e,Md.	
Baltimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other 900cs.		-	Service Lice Se	Ri		PĨ	ľĽľ	d Address	RÍNA		FUNER				,P.A. ,Md209	910
1	F - F		23a. Part1. Enter the dis shock, or heart failu	ease, or complic	ations that caused	the dea								OP1	1119	Approximate Interval Betwe	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	Chron	ic c	bstru									Onset and De	ath
	Examiner		Sequentially list condition	ns b.													
	D #	iner	Sequentially list condition if any, leading to immedicause. Enter Underlying	ate	Due to (or as	a consec	quence of):										
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as	2.00000	Tuesce of):										
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587		edicai		d.													
Box (	death certific e attending p id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent preg	nant 23	c. If yes, outcome								230	d. Date	of delive	v	
	that the death cer ed by the attendir detached for use	icia	in the past 12 month 1 ☐ Yes 2 ☐ No		1 Live birth 4 Pregnant at			JEctopic pro Other (sp.				·		Month		Day Yea	ar
P.0	tt the d by the tached	hys	9 Unknown		9LJ Unknown												
Ś	se da	by P	Part II. Other significant	conditions cont	ributing to death b	ut not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use			e cause of dea	
ord	w requir been si should	ted				-						1 <b>X</b> Y	'es 2 □ I	No 3	☐ Proba	ably 4 □Unk	known
ec	elawi hasb	Completed										24a. Was autop	sy	pric	or to com	sy lindings ava	
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Vital Record	Physician: The this certificate har director, page	Be	25. Was case referred to examiner?	1.7	spital:				Otho	r		Check only o					
o	Phys this al di	-: To	1 ☐ Yes 2 █No 27. Manner of Death	110	1 Inpatie		28b. Time of		8c. Injury	4 (40		5 Resid				)	
	ding th. After funer	tion		Pending investigation	(Month, Da	y Year)	Injury	M	Work'	? es 2 □		d. 20001100 11	ow injury c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Division	l or Atter after dea Diractor	Certification:		Could not be determined	28e. Place of Injuding, etc.	ury - At h c. (Speci	nome, larm, str fy)	eet, lactory	, office		28	f. Location (S City or Tow		Vumber	or Rural	Route Numbe	ır,
-	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai C	29a. Certifier 1 1 2 (Check only one)	Certifying Physi Medicel Exemin	cien: To the best er: On the basis of and manner sta	examina	owledge, deatl ation and/or in	n occurred a vestigation,	at the time in my opi	e, date an inion, dea	d place, an	d due to the d at the time, d	cause(s) ar date and pl	nd mann ace, and	er as sta d due to	ated. the cause(s)	
	o the	Med	29b. Signature and title o	f certifier	and mainer ste			29c	. License	number		- 2	29d. Date s	signed (	Month, £	Pay, Year)	
1	0		) / Que	Conta.	11111				D3	9793	3		Mar	ch	14,	2007	
	20		30. Name and address of	person who con	npleted cause of d	eath (Iter	m 23a) (Type.	Print)				1					
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	Sta Registr		31. Date filed (Month, Da		32 degistra	ar's Sign	ature	esti 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 19,2007 **Physician** Jeffrey Allen Davies 3:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Clinton Convalescent Center Clinton Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Director Mar 9, 1975 MD Usua 135 31 0542 <del>32</del> 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 ☐ No Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 21502

13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 120 Oak Street 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or DatesX 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed wintent of Health and Mental Hygier tant: If Item 27 is marked other the jury or other traumatic event, the 17. Father's Name (First, Middle, Last) <del>n/a</del> 18. Mother's Name (First, Middle, Maiden Surname) æ ဥ William E. Davies Helena C. Hull Davies 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trains once. P.O. Box 1055 Scott Davies brother Kevser WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/22/2007 Scarpelli Funeral Home, P.A. Cresaptown MD21. Signature 1 uneral 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate interval Between Onset and Death Immediate Cause (Final Acute Myocardial Infarction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Dequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed <u>Generalized Atherosclerosis</u> burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 End Stage Renal Disease 1 Tes 2 No 3 Probably 4 Unknown Completed Dialysis Dependent 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was .... autopsy performed? Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗙 No Other: P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5☐ Residence 6 ☐ Other (Specify) al or Attending Physical States death.

I Director: After this st in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital c filled i To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-45490 March 19, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 106 Irving Street, NW Tower 415 Washington, DC Yudh Vir Gupta, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2007

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After it completely filled in by the funeral

State

(Check only one)

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29b. Signature and title of certifier

Eckinen

Year,

Registrar DHMH 17 Rev 1/2001 Gallant

29c. License number

Foclare

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29d. Date signed (Month, Day, Year)

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and manner stated.

14300

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Iter any Injury or other traumatic event, the Medical Examiner

**Physician** 

/Medical

sician and bunial-transit

physician sthe burial

Examiner

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2007 Month Otto Tobias Friedrich, Jr. March 11, 12:18 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Medical Center Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 3/23/1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Sex 1XXM 2□F Days Hours 214-30-1165 74 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Maryland Anne Arundel Edgewater Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 River Road 21037 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1951-55 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker Woodworking 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Tobias Friedrich Clara Welch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille B. Friedrich/ Wife 110 River Road, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemeterv 3-16-07 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service 2973 Solomons Island Road, Edgewater, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) schemic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2KER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of D ath 28d. Describe how injury occurred Certification: Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12,2007 D58166

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Phe within 24 hours after death.

To the Funeral Director: After the ompletely filled in by the funeral

12 KIVA State Registrar

3169 Braverton Rd., Edgewater, MD 21037

and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 2007

32. Regis

r's Signature

Eric C. Marcalus, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 12, 2007 1730 Ferguson Emma Sally Avery /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗙 F Days Hours Min 89 278-30-0421 Director 9/09/1917 Indiana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Ex-miner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring Md Montgomery Funeral Director 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 2334 Jones Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Completed by Specify: Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) New York City Paramedic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Avery Emma Cunningham ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E.Ferguson/Daughter 2334 Jones Lane Silver Spring, Md 20902 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Chesapeake Crem 3/15/2007 Beltsville, Md. 4 □ Donation 5 ☐ Other (Specify) 21. Signature AF eral Service Li PHILIP OC. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute myocardial infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Noundary After this certificate has been si funeral director, page 2 should h 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1☐ Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death Check onl one Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attendential within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M DR63579 March 12,2007

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maria J. Tayag MD

1500 Forest Glen Rd Silver Spring, Maryland 20910

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	90	cility Name (if i 00 Seton Dr	rive	n, give str					b. City, Town, o Cumberlan				Alle	ounty of Death gany	
Funeral Director	21'	ial Security Nu 7-86-08	27	6. Sex	2F	7. Age (li 32	n yrs last bi	rthday) Yrs.	If Under 1 Yes		Min	Date of Birth		Foreig	hplace (State or n Maryland untry)
áu	Usual 10a. S	Residence of I	Decedent 0b. County			10	c. City, Towr	or Location	on.						10d. Inside City Limits
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3 L	rital Status Never Married Widowed	4 Div	arried 1 proed If Y	Nas Dece Armed For Yes es, Give Year Dates:	rces? 2 X	No	If Ye	S Decedent of Hi es, specify Cuba Yes 2 X No	n, Mexican, P	Puerto Rica	n, etc.)	Spe	White, etc. ecify: Wh	ite
5-0036 ed within 72 hours tyglene. other than "natur the Medical Exam Completed 1	15. C	nentary/Secon		cify only h	ighest grade College (1-		eted) 16a.	during mo	's Usual Occupa est of working life Laborer			done		of Business/I	Production
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica o Be Comple	F	ther's Name (F °ank	C	nrist	opher	7	Fi	lippo	one	18.Mother's Judy		st, Middle, Ma Le			lingler
MD 21 ad 2 should dith and Me m 27 is ma aumatic ev	Jı	formant's Nam udy Fil	ippon			1		12102		len Hig	ghway	, Cumb	erla	nd, MD	21502
Baltimore, permit Pages I an Department of Heal Important: If iten njury or other tra	글							/2007	Cu	mberla	nd, MD				
Ball permit Depart Impor injury	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  404 Decatur Str						reet,	Cumbe	rlan	d, MD	21502				
Physician /Medical Examiner	fa	art I. Enter the illure. List only fiate Cause (Fi	one cause	on each I	ine.				e mode of dying				t, shock,	or heart	Approximate Interval Between Onset and Death
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760, icate be execuphysician and the burial - tra	X	UNPENDED			#23a,2				366, 4/2/2	2007 TT			Lanta		
Records, P.O. Box 68760, The law requires that the death certificate be executed reate has been signed by the attending physician and page 2 should be detached for use as the burial - transiconmoleted by Physician/Medical E.		MALE: las decedent plast 12 months?  Yes 2 No		e 1	Live bi	rth ant at tim	of pregnancy se of death	2 Fet	al death 3 ner (Specify)	Ectopic p	pregnancy			ate of delivery nth E	day Year
Division of Vital Records, P.O. Box 68 tall or attending Physician: The law requires that the death certif as after death.  **A Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as perfification: To Be Completed by Physician	3	Other signifi	cant condit				ut not resulti	ng in the u	nderlying cause	given in Part	: <b>I</b> .				the cause of death?
Records,  The law requires fricate has been sig spage 2 should be	_										- 1	24a. Was ar autopsy perform 1 Yes 2	y ned?		topsy findings available completion of cause of
Vital Recysician: The last certificate la director, page		as case referre	ed to medica						26.Plac	e of Death (C	Check only			· V	3 2 10
Vital hysician this cert d directo	<b>i</b> ex	examiner? Hospital: 4 Inneticet 3 FR/Outpeticet 3 DOA Other, Nur							Nursing Ho	ome 5 R	esidence	6 🗸 Other	Scene		
on of \number of the of the office office of the office of the office of the office office of the of	27. Manner of Death  Natural  Natural  Natural  Negretication  1 Natural  Negretication  1						- 1	. Describe ho	ow injury o	occurred					
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:	3 4	Accident Suicide Homicide	6 X Coul	tigation d not be mined	28e. Place	of Injury		farm, stree	t, factory, office	building, etc.	28f.	Location (St	ate)	Number or Ru	ral Route Number, City
Division of Vital  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificantle on the funeral director.  Completely filled in by the funeral director.  Medical Certification: To Be (		Pa. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dune)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated						e, and due	to the cause	(s) and m	anner as state	ed.			
To To Cor	200.5	signature and to	itle of certifie	an er	u manuer st	, gred				se number				e signed ( <i>Mo</i>	oth, Day, Year)
\$		ame and addre							n Street, Ba	Itimore, M	D 21201				
State Registrar Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD. Registrar's Signature 2 9 2007															

State of Maryland / Department of Health and Mental Hygiene

			_ FOr	ertificate of Death	eg. No.
	Physici		Decedent's Name (First, Middle, Last)  RUTH GENTRY	2. Date of Dea Month 03/08/2	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	and the second		12506 Chalford Lane	Bowie	Prince Georges  9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number  498-10-5036  6. Sex  1 M 2XX 7. Age (In yrs. last birtho	Months Days Hours Min (Month Day	Year) Country) 1919 Illinois
	aryland show d at	Ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	Location	10d. Inside City Limits 1 1 1 1 1 2
	the Ma 28a-f	ecto	Maryland   Prince Georges   Bowie	10f. Zip Code	Og. Citizen of What Country?
	3a or	Funeral Director	12506 Chalford Lane	· ·	USA
	ems 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>	14. Race - American Indian, Black, White, etc.
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XNo If Yes, Give 3 【XWidowed 4 ☐ Divorced Year or Dates:	1 □ Yes 2 No Specify:	Specify: White
ה ה	"natu	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) ((	ecedent's Usual Occupation five kind of work done during most of working fe. DO NOT use retired)	16b. Kind of Business/Industry
7	withir iene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+)		Own Home
מוומ	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Surname)
yla	ould b Ment iarked	To		Frances Kemper	
Mal	and 2 sh ealth and 1 27 Is m er traum			ailing Address (Street and Number or Rural Route Numbe 5 Spiral Lane Bowie, MD 20	• • • • • •
5	ges 1 g		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	sposition (Name of Date crematory or other place)	20c. Location - City or Town, State
Daltillo	it. Pag rtment rtant: njury		4 □ Donation 5 □ Other (Specify) Huntt	103/23/2007	Waldorf, MD
0	permi Depar Impo any ir		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Robert E. 16000 Annapolis Road Bowie	
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition Congestive Heart		Onset and Death
P.	/Medical Examiner		resulting in death)  Due to (or as a consequence of)	-	
S	d apa	er	Sequentially list conditions, if any, leading to immediate  b. Cardiomyopathy  Due to (or as a consequence of)		
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Out 10 My Opathy  Due to (or as a consequence of)  Dementia		
00/00	tificate be executed ig physician and as the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of)		
00	ificate g phys as the	edical	d		
Y O	th cert tendin r use	sician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
5	the deach the at	ysici	in the past 12 months? 1 ☐ Yes 21ZNo 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)	World Bay Tour
ŗ.	s that t ned by e detac	by Phys	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?
ecolos,	equires en sig oufd be	ed b		1 U Y	es 2 <b>X</b> I No 3 ☐ Probably 4 ☐ Unknown
ב	law range law range be	Completed		24a. Was a autop	sy prior to completion of cause of
	n: The				med? death? 2 X No 1 ☐ Yes 2 ☐ No
NI G	rsleiar s certif lirecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	26. Place of Death (Check only or tient 3 DOA Other: 4 Nursing Home 5 🛱 Resid	
VISION OF	ng Phy ter this neral c	n: To	27. Manner of Death 28a. Date of Injury 28b. Tir 1 Natural 5 Pending (Month, Day Year) Inju	e of 28c. Injury at 28d. Describe h	ow injury occurred
<u>5</u>	tendir eath. tor: Ai the fu	catic	2 Accident investigation	M 1 Yes 2 No	
2	tal or At s after d al Direct ed in by	Certification:	3 ☐ Suicide 4 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office 28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely illied in by the funeral director, page 2 should be detached for use	Medical (	29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	eath occurred at the time, date and place, and due to the or investigation, in my opinion, death occurred at the time,	ause(s) and manner as stated. date and place, and due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
)	1		1 ( '. ) (	- D58182	1/2/01
	D		30. Name and address of person who completed cause of death (Item 23a) (Ty Donald George, MD., 8118 Good Luck		
5.4	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registi		MAR 1 3 2007	Soull	
DH	MH 17 Rev 1/2	001	No.		

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 03/12/2007 6:45 aM Robert Dean Glascoe 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Edgewater Anne Arundel 4105 Shoreham Beach Rd. If Under 1 Year | If Under 24 Hrs. 6. Sex 1 AM 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. Hours Months Days 01/20/1927 80 Washington, DC 577-30-9352 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No MDAnne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4105 Shoreham Beach Rd. 21037 USA 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1944— If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗓 No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steam Fiter HVAC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Albert Glascoe Libby Marie Kossmar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 Shoreham Beach Rd. Edgewater, MD 21037 Phyllis Glascoe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 03/16/2007 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oncu Stive to Due todor as a consequence of) 5 days Arcliomy DAUNG Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5,mbolus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at any Injury or other traumatte event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

attending physician and for use as the bunal-transit

been signed by the s should be detached

Division or Vital Records, P.O. Box 68760, Physician/Medical 23b. Was decedent pregnant Completed the Hospital or Attending Physiclan: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 1 M Natural 5 ☐ Pending investigation 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) o the Hr within 2 To th and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Pay

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

mb 1141 216 MArch 13, 200

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify)

28d. Describe how injury occurred

bestgate Rd

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 2007 7:15 PM Joyce Gross March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1005 Old Bay Ridge Rd. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Year) 1 □ M 2X F Director 214-56-1974 56 Feb 17 1951 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County Maryland Anne Arundel 1X Yes 2 No Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with "natural", or items 23a 1005 Old Bay Ridge Rd. 21403 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Heaith and Mental Hygien
Important: If item 27 is marked other the
any injury or other traumatic exer-Addiction Counselor Second Genesis 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Dennis Aristine Jacobs 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dionne Sanders(Daughter) 6410 Jefferson Place Glen Burnie, Md. 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter), crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 3-15-07 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Windlame Richers of Eacilisons Mortuary, P.A. Zavony S. Agesse Mooy 83 | 821 West St. Annapolis,

23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 one week /Medical Due to (or as a consequence of Examiner one wee sortielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | the a 9□Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 XNo page 2 certificate 1 ☐Yes 2 ☐ No Division or Vital or Attending Physiclan: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 2 After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

within 24

State Registrar

31. Date filed (Month Day, Year) MAR 1 4 2007

De

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annaholis

29c. License number

Donna

29d. Date signed (Month, Day, Year)

nambersmo

March 13,2007

			1 - For State Registrar	State of Ma	ryland	•	artment rtificate			and M		giene Reg. No.	21111	7	10049
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea	ith			3. Time of Death
	Physici /Medio		Thelma W. Gol	dsborough	1						March	Day 13		9ar 07	9:56P.M
>	Examir		4a. Facility Name (If not institution, give s	,	Dobo	h			Location o			4c.	County of I		
4			Westminster Nursi  5. Social Security Number 6. Sex		(In yrs. las		If Under		If Under 2		9 Date of Birt		Car		
	Funeral Director			м ЖЖ	96	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Feb. 1.	Year)	911	Coun	ace (State or Foreign try) ryland
	De J		Usual Residence of Decedent												
	shov	5	10a. State 10b. County  MD Carrol	,	10c. City,	Town or Lo	cation lersbu	ra						10	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	28a-f	Director	10e. Street and Number	.1		1510	10f. Zip					10c Citi	zen of Wha	t Court	
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E S	2 8 2 8		19a. Informant's Name/Relationship (Type Charles E. Goldsbo				g Address Stra				Route Numbe				<sup>Code)</sup> D <b>21784</b>
altimore,	- I 9 =		20a. Method of Disposition		20b. Plac	ce of Disponetery, cren	sition (Nam	e of her place	e)		ate		cation - City		
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g	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	Cause			. Name and irri er				al Home	& C	remat	ory	, PA
			23a art1 Enter the disease, or complic	cations that paused	the death.	113	112 W	_റ്1	JLib	ortv	Road	Win	field	I, M	D 21784 Approximate
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ecoras	aw re	Completed									24a. Was a		24b. Wer	e autop	sy findings available
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5	ital or irs afte ral Dir led in	Certification:		building, etc.							City or Town				
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	1.16		John W.	mild	loty	~	7	1)	544	13		3/	14%	212	OI
	MZ		30. Name a address of person who cor	npleted cause of dea	ath (Item 2:	3a) (Type, I	Print)	0					11		7
	7		John W. Mido	Caron 1	MD	688	100/0	R	d, h	lest	minste	1	MI	)	21157
	Sta Registr		31. Date filed (Month, Day, Year)  MAD 1 / 2	32. Registrar	r's Signatur	θ 	/				P	1			J /

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Goldring oruth 10:21 AM 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BaltiHore Maryland Med Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F Months Days Hours 217-60-9108 Director 6/19/1954 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show be notifled 1 X Yes 2 □ No Director Maryland Prince Georges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ò 4402 Morgan Road 23a r than "natural", or Items 23a the Medical Examiner must 20746 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygione. and the fram "natural", or freament If item 27 is marked other than "natural", or fream 17 or other traumatic event, the Medical Examineary or other traumatic event, the Medical Examineary. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 AAA Transportation <u>Insurance Specialist</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ James L Bealle Dorothy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Goldring/Daughter 701 Lamont St.N.W.#33 Washington DC 20010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or once, 3/16/2007 Pomfret, Maryland 4 Donation 5 Other (Specify) St Joseph 22. Name and Address of Facility Adams Funeral Home PA 191 20605 Aquasco Rd. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat vailure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): month Examiner Endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Į. in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should bo we 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 🗆 Yes 2□ No Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Natural 5 Pending Injury 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

Box 68760 o ص or Vital Records, Division 24 hours after death. Hospital completely within 2. To the I

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

22

1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

South Greene Street

29d. Date signed (Month, Day, Year)

			1- State of Maryland		artment of He rtificate of D			Jiene leg. No. 007	10051
П	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Yea	
4	-/Medic	cal	JAMES WENDELL GRA 4a. Facility Name (If not institution, give street and number)	NT	4b. City, Town, or L	ocation of Doath	MARCH	13, 200 4c. County of De	
	Examir	ier	VILLA ROSA NURSING HOME		MITCHEL			PRINCE	
a	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. E	irthplace (State or Foreign Country)
×.	Director		102-16-6955   83	Yrs.					TH CAROLINA
	yland tow at		10a. State 10b. County 10c. City, T	own or Lo	cation				10d. Inside City Limits
	e Mar la-fst tified	ctor	MD. PRINCE GEORGES		SEABROOK				1X1Yes 2 □ No
	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?
	eath v is 23a must	eral	5510 LINWOOD CT.  11. Marital Status 12. Was Decedent Ever in U.S.	10.1	207		- aif- \( \lambda - a - b \)	U.S.A	nerican Indian,
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1		Nas Decedent of Hisp f Yes, specify Cuban I □Yes 2🏿 No	panic Origin? (Spi , Mexican, Puerto <i>Specify:</i>	Rican, etc.)	Black, Wi	
21215-0036	72 hou natura ical E	ted	15. Decedent's Education 1		lent's Usual Occupati			16b. Kind of Busines	
21	ithin 7 ne. nan "r e Med	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. I	kind of work done du DO NOT use retired)	ring most of work	ng		
2	iled w Hygiel ther tl nt, th	S	9 17. Father's Name ( <i>First, Middle, Last</i> )		UNKNOWN	9 Mother's Name	/First Middle	UNKNOW Maiden Surname)	N
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, ti	To Be	THOMAS U. GRANT		'		THERINE	DINGL	F
ary	2 shou and M is mar aumat	-		9b. Mailir	g Address (Street an			r, City or Town, State	
	1 and 2 Health em 27 i		JEAN ARNAO/DAUGHTER	5510	LINWOOD	CT., SEA			
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		To bullar 2 poremation 3 to removal from State	e of Dispo etery, crer	sition (Name of natory or other place)	4		20c. Location - City of	or Town, State
Ħ	artmer artmer ortant injury		4 □ Donation 5 □ Other (Specify) CHAN  21. Signature of Funeral Service Øcensee	-	CREMATORY Name and Address			RIVERDA	
Ba	Dep lmp any onc		MM Chamberson MOOOS	01   C	HAMBERS FO 801 CLEVE	JNERAL HO LAND AVE	OME & CF	REMATORIUM RDALE, MD.	,P.A. 20737
×	1750		23a. Part1. Enter the disease, or complications that caused the death. E shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. ADULT FAILURE resulting in death)						Onset and Death MONTHS
	/Medical Examiner		Due to (or as a consequent		I.D.				
*		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		<u>E</u>				YRS.
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68760	flicate be executed g physician and as the burial-transit	edical	d						
Rox	death certifi e attending d for use as		IF FEMALE: 23b. Was decedent pregnant in the post 12 postbo2  1 □ Live birth 2 □ Fetal dec	ath of	I atania araana			23d. Date of d	elivery
о. В	0 0 0	Physician/M	in the past 12 months?  1   Yes   2   No		Ectopic pregnancy Other (specify)			Month	Day Year
_	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting	g in the ur	derlying cause given	in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Vital Records,	The law requires that the te has been signed by the sage 2 should be detache	d by					1 □ Y∈	es 2∐No 3∐I	Probably 4 Magunknown
ဝ	law requiras been si 2 should b	Completed	M				24a. Was ar		autopsy findings available
ř		Som				· · · · · · · · · · · · · · · · · · ·	autops perforr	ned?   death?	completion of cause of s 2 □ No
VIta	ysician: This certificate director, pag	Be	25. Was case referred to medical examiner?		Other	6. Place of Death	_	**	
	Phys	은	I Impatient 2 ERA	Outpatien  o. Time of		4 X Nursing Hoi		ence 6 Other (Sp ow injury occurred	ecify)
<u>0</u>	nding R tth. r; After e funera	ation	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injury a Work? M 1 ☐ Ye	s 2 □No	edd. Deddinbe no	w injury occurred	
DIVISION OF	al or Attending Physician: after death. I Director: After this certifica d in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office	2	28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
	To the Hospital or Atte within 24 hours after ded To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled to the best of my knowled and manner stated.	lge, death and/or inv	occurred at the time restigation, in my opir	, date and place, a nion, death occurr	and due to the ca ed at the time, d	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier		29c. License n	umber	29	9d. Date signed (Mor	nth, Day, Year)
•	1-VA		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		D32	261		3/13/200	47
			30. Name and address of person who empleted cause of death (Item 23a RICHARD J. FELDMAN, M.D. 9500			TANTITAN	MD O	0706	
	Sta	te	31. Date filed (Month, Day, Year) 32. gistrar's Signature		POLIS RD.	, LANHAM	, FID. ∠(	0/00	
	Sta	le	MAD 15 2007	13	made a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 200<u>7</u> March 10, **Physician** Peter VanVechten Hamill 9:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **X**M 2 □ F Yrs. 377-20-7954 Director 80 April 16.1926 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2/CXNo Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1001 Whitehall Cove 21409 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. WWII Specify: Completed by White 3 Widowed 4 Divorced s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 Is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Physician Public Health Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Northmore W. Hamill Priscilla L. VanVechten ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margot J. Hamill/Wife 1001 Whitehall Cove, Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 3/13/07 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Urinan /Medical Due to (or us a conse un nce of): Examiner Sequentially list conditions, any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Due to (or as a)consequence of) burial-Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Hinknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO 24a. Was an page 2 s has certificate 1□ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To this funeral o 27. Mannet of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after

To the Funeral Direcompletely filled in by 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 30. Name/and Hung /Davis, M.D., 2001 Medical Parkway, Annapolis, 21401

Registrar

31. Date filed (Month, Day, Year) MAR 1 3 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 3:15 AM March 10, 2007 Carl Harry Huhndorff /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Texas 214-28-3892 76 Director Sept.18,1930 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene. unt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2618 Vantage Cove 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2☐ No If Yes, Give Year or Dates: 1951— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: ģ white 3 V Widowed 4 □ Divorced Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 12 Aircraft Mechanic/Supervisor Commercial Airlines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl William Huhndorff Gladys Rose Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is,
any injury or other trau Harry Huhndorff / Brother 29480 Goulders Green, Bay Village, Ohio 44140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 3/16/07 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1/2/Yes 3 ☐ Probably 4 ☐ Unknown 2 □ No certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed/ death? 1 ☐ Yes 2 ☐ No 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes/ 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Mann of Death funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Aatural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registrar 29b. Signature and

30. Name and address of person

31. Date filed (Month, Day,

Year)
1 3

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Dav. Year)

nd #23a per amend fi	nd no	Ty 3/26/07 lo 22a per pl dept 3/14/0 - Registrar	Please	Type or F	Print in E Marylan	Black In id / Dep	delible artmer	e Ink. et of F	Ensi lealth	ure All	Copies ental Hy	s Are	<b>Legil</b> e	ole.		
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		Decedent's Name (First	t, Middle, La	st)							2. Date of D	eath D	av	Year	3. Time of	Death
Physici /Medi		Mitchell H.	Hubb	ard							March	12,	200	7	3:12	ΑM
Examir	ier	4a. Facility Name (If not in Anne Arunde	-					Town, o napo	rLocation	of Death			c. County		del	
Funeral Director		5. Social Security Number 307–16–7531		Nex MAM 2□F	7. Ag <i>e (In yrs.</i> 86	last birthday) Yrs.	If Under Months	_	If Under Hours	Min.	8. Date of Bi (Month, D 2/18/	irth		9. Birth	place (State ontry) tucky	or Foreigr
and *		Usual Residence of Deced	dent County		10c Cit	y, Town or Lo	ocation								10d. Inside Ci	ity Limita
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Physician //Medical Examiner  Sequentially list conditions, fany but in the state initiated events resulting in death)  Sequentially list conditions, fany but in the state initiated events resulting in death)  Due to (or as a consequence of):							Ed	gewat	er,	MD						
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Physician	8 1	Immediate Cause (Final	re. List only	one cause on ea	ach line.		CHO	MAC	10/1	COLA	1010	ŕ		- 1	Interval Bet Onset and I	ween Death
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and -trans	xam	that initiated events resulting in death) Last		C	25.25.25.20.20.20.20.20.20.20.20.20.20.20.20.20.	uonoo of):									19	
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nding use a	N/Me		ant	23c. If yes, outc	ome pf <u>pr</u> egna								23d. Date	of delive	erv	
e atte	icia	in the past 12 month: 1 ☐ Yes 2 ☐ No	s?	4□Pregna	ant at time of d		⊒Ectopic pi ⊒Other <i>(sp</i>		′			1	Mor		•	Year
by the	hys	9 ☐ Unknown		9□Unkno	wn											
igned I be det	by F	Part II. Other significant of	conditions	ontributing to dea	ath but not resi	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did	tobacco	use contri	bute to t	he cause of d	eath?
been si should											10	Yes 2	2□ No	3 Prob	ably 4 □L	Jnknown
as be	Completed										24a. Was	psv	24b. V	ere auto	psy findings a	available ause of
cate ,	Co										perf 1∐ Yes	ormed? 2 2 V	-   d	eath? □Yes	2□No	
certificate has t irector, page 2 s	Be	25. Was case referred to rexaminer?	medical	Hospital:				Oth			(Check only					
r this	- T	1 ☐ Yes 2 No  27. Manner of Death		28a. Date of	patient 2	28b. Time o		A Other	4 L N		e 5 Res				<i>y)</i>	
th. : Afte	ţi	<b>\</b> .	Pending investigation	(Month	n, Day Year)	Injury	м	Worl	່∢?ີ່ Yes 2 🗆		od. Describe	now mije	ny occurre	,u		
r deat ector by the	fica	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place o	I of injury - At ho	me, farm, str					3f. Location (	Street a	nd Numbe	er or Rura	al Route Num	ber,
after	Certification:	4 Homicide	dotorriniod	buildin	g, etc. (Specify	V)					City or To	wn, Stat	e)			
within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)	ertifying Ph ledical Exar	ysician: To the t niner: On the bas and manne	sis of examina	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date a pinion, de	nd place, a ath occurre	nd due to the	cause(s	s) and mar nd place, a	ner as s	tated. the cause(s	;)
vithin 24 To the F complete	Mec	29b. Signature and title of	certifier	and manne	er stated.		290	. License	e number			29d. Da	ate signed	(Month.	Day, Year)	
× - 0		▶ 4. X	lou	W/s C	0			VI	983	38		3	112	20	07	
12,		30. Name and address of	person who	completed cause	of death (Item	23a) (Type,	PriBer	toa	H R	Pd.	Anna	apo	lis, i	Mil	ı	
Sta	te	·		07 2. Re			_									
Registr	ar	MAK	1 4 20	UI	Me B	A STATE OF THE PARTY OF THE PAR										

			1 - For Amend Item 29	State of Marylan or per dr.,8667,0	5/03/ <del>0</del> 7/6/	ertment of F rtificate of	lealth and <i>Death</i>	Mental Hy	giene Reg. No. 2	07	10055
Vé	Physici	- n	1. Decedent's Name (First, Middle, Las	it)				2. Date of De Month	ath Day	Year	3. Time of Death
f	Physici /Medio		Carla Henderso	n				March	8 2	007	5:00 PM
	Examin	er	4a. Facility Name (If not institution, give	,		4b. City, Town, o		ith	4c. County	of Death	
	Silver sayon ser a service.		619 Lions Gate			Odent			Anne		
	Funeral Director		212-02-0101	ex	45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		2 1961	9. Birthp Coun Mary	ace (State or Foreign try) 1and
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
	Manyll f sho ied at	<u>10</u>	Maryland Anne A:	rundel Od	enton					1	1 □Yes 2XINo
	the 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	trv?
	3a ol		619 Lions Gate	T.ane		2111	3		USA		
	deat ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H		Specify Yes or No		e - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1	1	n Yes, specify Cuba 1 □ Yes 2 ŽŪNo	an, мехісап, Рие Specify:	по нісап, etc.)		ck, White, $_{V}$ : $B1$ $\overline{c}$	
Ö	72 ho natur lical B	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	oation	arking I	16b. Kind of Bu	usiness/Ind	ustry
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired	•	Jikiliy			
2	ed w lygier lygier lt, the	Co	12th	0	Tech	nician			MAIF		
Maryland	be fii htal H ed oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		ne)	
3	d Mer narke	은	James William  19a. Informant's Name/Relationship (7)	Jones	405 14-75			La Will:			
Z	d 2 sl th an 7 is r traur		Allen Henderson		1	ng Address <i>(Street</i> Lions G			er, city or rown, nton , N		
ض ر	1 an Heal tem 2		20a. Method of Disposition			sition (Name of		Date	20c. Location -		
timore,	ages ent of t: If it		1 🗗 Burial 2 ☐ Cremation 3 🗌	nemoval nom State		n <b>atèn</b> Park 1 Park		14-07	Annapo		
altir	nit. Partme	1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	,		Myame ProbAdde			1-		
ñ	Dep Imp any onc	0.0	Lavry S.	Reese MOOY8	-	21 West			-		1
В			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	rications that caused the death	n. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory ar	rrest,		Approximate Interval Between
16	Physician		Immediate Cause (Final disease or condition	. T	1(2)	Lundh	wMa				Interval Between Onset and Death
*	/Medical		resulting in death)	Due to (or as a consequ	uence of):	11					,,,
5	Examiner	_	Sequentially list conditions,	b		316					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					-	
	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	cDue to (or as a consequ	ience of):	<u></u>					
9	be e	al E		240 10 (01 40 41 00110041	207100 0171					ļ	
68760,	ficate phys s the	edical		d							
Вох	eath certificate be executed attending physician and for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	ncy				23d Dat	te of delive	n/
ň	death a atte	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)	/ 				Day Year
<u>Р</u> О	t the o	hys	9 Unknown	9□Unknown							
ώ,	w requires that the de been signed by the should be detached	by P	Part il. Other significant conditions co	ontributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to th	e cause of death?
ğ	equire en sig	ed k						101	∕es 2X Ño	3 Prob	ably 4 □Unknown
ည္က လ	aw re is bee 2 sho	Completed						24a. Was		Were autor	sy findings available
ř	The lav	E O						autop perfo 1□ Yes	rm,ed?   d	pnor to con death? 1 □ Yes	npletion of cause of
<u> </u>	ian; artifica	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		100	
<u>_</u>	ding Physician; The n. After this certificate he funeral director, page	20	1 Ves 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursing	Home 5 Resid	dence 6 □Oth	er (Specify	)
9	ng P		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	now injury occurr	red	
<u> </u>	tendi eath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division or Vital Records,	al or At after d Direct d in by	Certification:	4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rurai	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certii within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier (Check only one)	ysician: To the best of my knowiner: On the basis of examination	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	me, date and place	e, and due to the curred at the time,	cause(s) and ma	anner as sta	ated. the cause(s)
	o the ithin 2 o the omple	Medical	29b. Signature and title of centifier	and manner stated.		29c. Licenso	e number		29d. Date signed	d (Month I	Dav. Year)
•	⊢≶⊢ő		, ear	~ MD		D3	8158		March 9,		1 /
	40		30. Name and address of person who o	completed cause of death (Item	23a) (Type,	Print)		15			
			LISA A DMARZIO	2003 Medical 30 Registrar's Signa		Suite	IDU, A	rigioli	/MD 2	1901	
	Sta Begistr		31. Date filed (Month, Day, Year)	3 Mari	Land	all 1					

Barbara Henslei		1- For State Registrar	St	ate of Ma	ryland /		rtment o tificate of			Mental H		Reg. No.	200	7	005
Physici Medical Exami		Decedent's Name     Barbara     4a. Facility Name (if	J. 1	Hensle				Ab City T	our or l	ocation of Death	2. Date of De Month March 13	Day , 2007	Year  County of Dea	105	of Death 1 hrs
		Union Hospi		on, give street a	ina number)			Elkton		ocation of Death			ecil	ıtn	
Funeral		5. Social Security N	umber	6. Sex	7. Age	(In yrs. la	ast birthday)	If Unde	r 1 Year	If Under 24Hrs	. 8. Date of B	irth (MM/I	DD/YYYY) 9 E	irthplace (	State or
Director		472-44-	2240	1 M 2	XF	6	6 Yrs	Months	Days	Hours Min	Septer	nber 1	18,1940 G	ountry)	<b>1</b> N
٨.		Usual Residence of 10a State	Decedent 10b. County			10 01	Town or Locat							14041	1- 01-11-
ow any								ЮП							ride City Limits
daryland 28a-f show 1 at once.	cto	MD 10e. Street and Num	Cecil			IVOI	th East	10f. Zip	Code			10a Citiz	zen of What Co		
ith the Maryland 23a or 28a-f sho notified at once.	Director	111 Invern		CSL7				2190				_	S.A.	and y	
0036 within 72 hours after death with the Maryland jene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	<u></u>	11. Marital Status		12. Wa	s Decedent	Ever in U.		s Deceder	nt of Hispa	anic Origin? ( Sp			14. Race - Ame	erican India	n, Black,
r death or iten must b	Funeral	1 Never Marrie	ed 2 M	arrieu	ned Forces? Yes 2	X No	If Y	es, specify	Cuban, I	Mexican, Puerto	Rican, etc.)		White, etc.		
after	by F	3 Widowed		orced If Yes, Gi	ve Year		1	Yes 2						ite	
036 thin 72 hours after ne. cthan "natural", c ledical Examiner r	eg	15. Decedent's Edi								n (Give kind of v DO NOT use reti		16b. K	(ind of Busines:	s/Industry	
0036 within 72 iene. rer than *	be	Elementary/Secon	ndary (U-12)	2	ege (1-4 or 5	1+}	Har	ewife					Househo	14	
5-00 led with Hygiene other	Completed	17. Father's Name (I	First, Middle				nous	CMITC	18	B.Mother's Name	(First, Middle,	Maiden		щ	
	Be (	Farl Tinke	Y							Bessie S	Sixberry				
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental tt: If item 27 is marked other traumatic event,	2	19a. Informant's Nar			t )				•	and Number or F			ty or Town, Sta	te, Zip Cod	le)
e, MD 2 hou I and 2 shou Health and I litem 27 is retraumation	ŀ	Carla Hens 20a. Method of Disp		ghter		205 0	88 Place of Dispos	Danie	Bart	han Dr.,	Elkton,		21921 Location - City (	or Town St	ata
altimore, Nrmit. Pages I and spartment of Health sportant: If item jury or other trau				3 Remo	oval from Sta	te c	rematory or ot	ner place)	e or cerri	,	h 16,		,		
Baltimo permit. Page Department ( Important: injury or oth		4 Donation 5 21 Signature of Fur	Other S	pecify:		R•A•	Ferris	Inc.	N	2	007	W	est Chest	er, P	<u> </u>
Bal permi Depar Impo		Z I SIGHATURA OF FUR	ngrai Service 00	Licensee						Funeral	Home				
Physician		23a. Part I. Enter the			that caused	the death.	Do not entert	e mede à	fajing S	deras carakte	respiratory a	21921	ck, or heart		ximate Interval
/Medical	a 70	failure. List only Immediate Cause (F		0	inhalatio	n								Betwe	een Onset and Death
Examiner		or condition resultin			r as a conse		T):								
	<u></u>	Sequentially list con		b.	r as a conse	auence of	· \-							+	
	Examiner	cause Enter Under	rlying Cause		as a conse	quelice of	1.								
isi ed (	Xar	events resulting in o		Due to (o	r as a conse	quence of	F):								
50, te be executed ysician and burial - transit	g	UNPENDED		dAMENI	DED									+	
30, re be e ysicia	ledical					o of aroas	20001					226	1 Date of dollar	20/	
Division of Vital Records, P.O. Box 6876( Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicily filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent p past 12 months'		20	yes, outcon Live birth	ie oi pregr		tal death	3	Ectopic pregna	ancy	230	d. Date of delive Month	Day	Year
OX 6 ath ce	Sici	1 Yes 2 N			Pregnant at	time of dea	ath 5 Ot	her (Spec	ify)						
O. Bo t the de by the ached f		Part II. Other signif		9	Unknown	but not re	esulting in the	ınderlyina	cause div	en in Part I	23e. Did	tobacco	use contribute t	o the caus	e of death?
ires that the signed by	þ	, and an odinor original	, out out ou		ang to doda	Datifiction	Journal of the Control	andonying	oddoo gir	on the diet.			No 3 Pr		
ords, w require s been si	Completed										24a. Was				dings available
COF e law r e has b	힏											orm <u>ed</u> ?	death?	,	n of cause of
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be		25. Was case referre	ed to medica	1				2	6 Place o	of Death (Check	only one)	2 N	0 1 🗸	Yes	2 No
/ita ysician nis cer directe	o Be	examiner?	2 No	Hospital: 1	Inpatie	nt 2 🗸	ER/Outpatient			Mar -	ng Home 5	Reside	nce 6 Oth	er:	
n of Vi ling Physi After this funeral dir	-1	27. Manner of Death		28a.	Date of Inju	ry	28b. Time of	njury 2	8c. Injury	at Work?	28d. Describe				
ion tendin eath. tor: /	턃	1 Natural 2 Accident	5 Pen	ding Ma stigation	(Month, Day Y ir 13, 2007	July 1	0948 hrs		1 Ye	es 2 🗸 No	Victim of h	ouse II	16		
ivisior or Attenc after death Director:	ij	3 Suicide	6 Cou	Id not be 28e	. Place of In	ury - At ho	ome, farm, stre	et, factory,	office bu	ilding, etc.	or Town.	State)	nd Number or I	Rural Route	Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide			ecify) Mo				_		111 Invernes	s Dríve	, Elkton, MD		
To the Hospital within 24 hours To the Funeral completely filled		(01100110111)								e and place, and death occurred a					s)
To the within To the Complet	Medical	29b. Signature and		and mar	nner stated				License		,		Date signed (A		
	-	4		n	Ti				O.C.M				ch 14, 2007		
		30. Name and addre				eath (Item	23a)								
5		Ling Li, MD		nt Medical			Penn Stree	et, Baltir	nore, N	<b>1</b> D 21201					
	ate	31. Date filed (Monti	h Day Year)		32. Registra	's Signatu		a de a		_					
Regis	trar	IAIY	K 1 6	2007	DEPLAS	1 As	· Perpor		_						

		1 - For State Registrar	State of Mary			of Health of Deat			giene Reg. No. (	007	10057
Physici /Medic		1. Decedent's Name (First, Middle, Last) ELEANOR SKINNE						2 Date of Dea Month MARCH 1	ath 2, Day 20	007 Year	3. Time of Death 12:32 PM
Examin	er	4a. Facility Name (If not institution, give s  34 MATHEW DRIVI  5. Social Security Number 6. Sex	Ε	yrs. last birthday)		wn, or Location MPTON Year If Under	n of Death er 24 Hrs.	8. Date of Birt	4c. Co QUE	EEN ANN	
Funeral Director			3 ,	O Yrs.		Days Hours		03/16/	1926	Cou	mtry) MD
e Maryland ia-f ehow	ctor	10a. State 10b. County MD QUEEN AND		c. City, Town or Lo	MPTON						10d. Inside City Limits 1 Yes 2 □ No
th with th	ai Director	10e. Street and Number  34 MATHEW DRIVE	E		10f. Zip Co				10g. Citize	n of What Cou	ntry?
17215-0036 within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-1 ehow the Madical Expluinations to be mailled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Was Deceden If Yes, specify	_		ecify Yes or No- Rican, etc.)		. Race - Ameri Black, White pecify: WHI	, etc.
21215-0036 od within 72 hours afr giene. or then "natural; or the Wedical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	cation e completed) College (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use r EMAKER	tone durina ma	ost of work	ing		of Business/Ir  HOME	ndustry
Maryland nd 2 should be file lith and Mental Hy 27 is marked other rtreumatic event,	To Be C	17. Father's Name (First, Middle, Last) WILLIAM ALBERT					BERTH	e (First, Middle, IA PAULI	NE DU	RHAM	
		19a. Informant's Name/Relationship (Ty) ELLEN HOLLETT/DAUG  20a. Method of Disposition 1 ☑8urial 2 ☐ Cremation 3 ☐ R	CHTER 2	34 1 Ob. Place of Dispo cemetery, crer	MATHEW esition (Name in matory or other	DRIVE,	CRUM	IPTON, D	M 216	128 tion - City or T	own, State
Baltimore, permit. Pages 1 a Department of Her Importent: if Item eny injury or othe		4 □ Donation 5 □ Other (Specify)  21. Signature Struneral Service License	1	CRUMPTON	Name and A	iddress of Fac	ility	5/2007 AND NE STERTOW			
DAYOU, Icate be executed /Medical Examiner  Physicien and Examiner and site burial-transit	Examiner	23a. Part1. Enter the disease, or compliance, or compliance, or compliance, compared tailure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co					or respiratory an	rest,		Approximate Interval Between Onset and Death
The colinas, F.O. BOX 00/00,  The law requires that the death certificate be ex ten has been signed by the attending physician is age 2 should be detached for use as the burial	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregri	nancy fy)			23d	d. Date of deliv	ery Day Year
es tha gned	by P	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying caus	e given in Par	t I.		bacco use		he cause of dealh?
NY VITAI MECOFY INSECTIFICATE HAS BEEN IS CERTIFICATE HAS BEEN I director, page 2 should	Completed	Sevene Dojei	resalire p	Intuites	Bette	tue.		24a. Was a autopoperfor 1 Yes	sy med?	prior to co death?	opsy findings available impletion of cause of
7 2 2 7	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien  28b. Time of Injury		04	Nursing Ho	me 5 Resid	ence 6		(v)
pital or Attentions after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	pecify)				City or Tow	n, State)		al Route Number,
n 24 h n 24 h he Fur detely	Medical	29a. Certifier (Check only one)  1  Certifying Phys 2  Medical Examin  29b. Signature and title of certifier	ician: To the best of my er: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	estigation, in	he time, date a my opinion, de cense number	eath occurr	ed at the lime, o	late and pla	ace, and due to	Day, Year)
8		30. Name of d address of person who	be The	(Item 23a) (Type,	D Z	3889	10210	- 0	3.	/13/0	7
Star Registra		30. Name of d address of person which the control of the control o	32. Registrar's S	Signature	Bush	eet, C	14.60	ar pragre	rea	7/4/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Day Physician Harper. 5, 2007 4c. County of Death pencer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clinton Maryland
6. Sex 7. Prince Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 227-32-9412 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Virginia 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 3224 Loganwood Drive United States 23834 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other transment. Elementary/Seçondary (0-12) College (1-4or 5+) Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Harper Reaves Nola ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3224 Logan wood Dr. Colonial Heights Va. 23834 ce of Disposition (Name of Date 200 Location - City or Town, State Frances Clarke (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 12, 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Dinwiddie Memorial Petersburg, Va. 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.M. Wilkerson Funeral Establishmi 102 South Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Petersburg Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE CORONAM SYNDROME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE CONGETIVE HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No MALLIATUS 24a, Was an page 2 s certificate has autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending Investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hehe D50689 WD

State

31. Date filed (Month, Day, Year)

MAR 2 6 2007 Registrar

SOUTHERN MANYLAND

HOLDITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILIS. MATIA 30.

CENTER

7503 SURRATTS

RD

CLINTON MD 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Robert Eugene Harris 2007 1:00 /Medical 14 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F 218-34-1938 Yrs Director 69 4/27/1937 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other then "naturel", or iteme 23a or 28a-f show other treumatic event, the Medical Exact armust be inclided at 1X Yes 2 □ No Director Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 1103 South Main Street United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "7 ery rigury or other treumatic event, if a Med 9008. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Harris Lillie Rill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Harris - Wife 1103 South Main Street Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 3/17/2007 Hampstead, Maryland Hampstead Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home, 934 South 21. Signatur III uneral Service Licensee M00723 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician - cancer - end stag disease or condition resulting in death) Unkroun /Medical Due to (or as a consequence of): Examiner OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) noting physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No 4 | Unknown

Box 68760 Division of Vital Records, P.O. sate has been signed page 2 should be del Hospitel or Attending Physicien: Siu After t

Completed Be Certification: after death.

24 hours after of Funerel Direct To the I within 2 To the WJL ٦

Medical

24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one,

21102

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Tyes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yey 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified

25. Was case referred to medicat

examiner?

H0061206

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manchester MD

475 A el 31. Date filed (Month, Day, Year)

2007

32. Registrar's Signature

Registrar

			State 3-13-07 RegistraAmend #20b.Pe	State of M	Maryland / Dep	partment e <i>rtificate</i>	of He	ealth a <i>eath</i>	ind M		iene	07	10060
is the	Physici	an	1. Decedent's Name (First, Middle, Last)  Maria L.							2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic Examin	67	4a. Facility Name (If not institution, give s Prince George's Hospit	treet and number al. Center	r)	4b. City, To	own, or L		f Death	March 4	4c. Count Prince		
	Funeral Director		219-76-1884	M 2XXF 7. A	Age (In yrs. Jast birthda 64 Yrs.	y) If Under 1 Months I	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, ADTIL 19	, °°£942	COL	place (State or Foreign intry) ginia
	Maryland f ehow	lor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince Geometric  Maryland	inge's	10c. City, Town or		Glena	ırden				7	10d. Inside City Limits ty⊠Yes 2 □ No
	3a or 28a-	I Director	10e. Street and Number 8626 Fulton Avenue			10f. Zip C	Code	20	706	1	0g. Citizen of U.S.		untry?
920	72 hours after death with the Maryland natural; or iteme 23a or 28a-f ehow Agal Examine must be natified at	by Funeral	11. Marital Status  11. Marital Status  12. Married 2 Married 3 Widowed 4 Divorced	2. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	\$? <b>X</b> No	3. Was Deceder If Yes, specific	y Cuban,	panic Orig , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc. 3CK
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. Itam 27 is marked other than "naturet; other traumatic event, the Mudical Ex-	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Gir	cedent's Usual ve kind of work DO NOT use	done du retired)	<i>iring</i> most	of work	ng	16b. Kind of E		ndustry
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ylan	ould be Menta Marked Maric ev	ToB	William I							Maria I			:- C- 4-1
	nd 2 sh alth and 27 is rr r traurr		19a. Informant's Name/Relationship (Ty, Mr. Gregory Hayes (So		19b. Ma 6036	Richmon	d Ave	arue A	pt. #	#215 Alexa	ndria, \	Trgin	ia 22303
Baltimore,	Pages 1 and 2 lent of Health int: if item 27 iny or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	20b. Place of Dis Gleffwood	position (Name remeter another LVCE CAME	er place,	Mean			20c. Location Ashingto		_
Balti	permit. Pages 1 Department of H important: if its eny injury or ott		21. Signature of Funeral Service License	eur .		22. Name and 4339 Hunt				llins Funs gton, DC		e, Inc	
	Physician /Medical Examiner		23a bart1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caus e cause on each Due to (or a	Myo Cou	relial	iv	nfa	rei	tion ligens			Approximate Interval Between Onset and Death
30,	ate be executed hysician and the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		as a consequence of):	beter hblo	\$ I	he	1,+	ันร			
68760,	ate the	edicai			11 17	nun		71 F	163.	surc			
P.O. Box	The law requires that the death certifics the has been signed by the attending proage 2 should be detached for use as it	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death	3 □Ectopic prec 5 □ Other (spec						ate of deli	very Day Year
	w requires that the de been signed by the a should be detached t		Part II. Other significant conditions con	_		underlying cau	_				bacco use coi es 2 □ No		the cause of death?
Division of Vital Records,		Completed								24a. Was a autops perfor 1 Yes	in 24b sy med? 2 No	death?	topsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	itient 2□ER/Outpat	ient 3™ DOA	Othor	-		h (Check only or ime 5□ Resid		that /Sna	2464
on of	ding h. After fune	ition: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		of 28	c. Injury : Work?	at		28d. Describe h			aiy)
Divis	ء ۾ ٿي ڍ	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At home, farm, etc. <i>(Specify)</i>	street, factory,	office			28f. Location (S City or Town		ber or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai (	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ner: On the basis and manner	et of my knowledge, de s of examination and/or stated.	ath cosumed a investigation, i	t tha time in my opi	inion, dea	d placs th occur	and due to the tree at the time, d	ausa(s) and n late and place	nainner as , and due	stated to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier  Touth  O	nee	M . O	D		32		/	3151		
R			30. Name and address of person who oc 9470 - Anna Pa	mpleted cause o	f death (Item 23a) (Type God - Suit	e 418	ale	h	Do	m M	M.D	207	06
) b a	Sta		31. Date filed (Month, Day, Year)		strar's Signature	1							

Maria lee Hayes

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		1 - For State Registrar	State of Maryland		ificate of		F	leg. No.	
		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	th Day Year	3. Time of Death
Physici /Medi		William Mar	tin Harley	7		·	March	9, 2007	12:08 <sup>A</sup> M
Examir		4a. Facility Name (If not institution, give	street and number)			or Location of Dea	ith	4c. County of Dea	
		Washington Advent	ist Hospital		Tacom If Under 1 Year	a Park	S 9 Date of Birth	Montgome	
uneral		5. Social Security Number 6. Security Number 1	9x □ 7. Age (In yrs. In X 50	Yrs.	Months Days				rthplace (State or Foreig Country) Virginia
irector		Usual Residence of Decedent	X 30				loctoper	20,1930	VIIgIIIIa
M M		10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limit
Department of health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, It is Medical Examinating the rediffied at once.	ţō	MD Prince	George's Col	lege P	ark				1 X Yes 2 □ No
7 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
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SE E	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. W	as Decedent of	Hispanic Origin?	Specify Yes or No- irto Rican, etc.)	14. Race - Am Black, Wh	
or Ite	2	1 Never Married 2 Married	1 ☐ Yes 2 █️No If Yes, Give		☐ Yes 25 No		,	Specify: Wh	
2 2	db	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:						
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even	Be	17. Father's Name (First, Middle, Last)						Waldell Sullaine)	
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raun raun		19a. Informant's Name/Relationship (7			4 T. H. 1944			r, City or Town, State,	Zip Code)
m 27 her t		Crystal Harley-Da		451 C	ulpeper	St., Wa	rrenton,	VA. 20186 20c. Location - City o	r Town, State
or of		1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	emetery, cremi	atory or other pl				
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Impor any in pnce.		21. Signature of Funeral Service Licen	"Ne de		Name and Addi Murphy	Funeral	Homes		
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attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregna	ncv				23d. Date of de	elivery
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erel Director: After this certific lilled in by the funeral director,	Certification;	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	′)			City or Tow	m, State)	
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<b>E</b>	Physic	ian	Decedent's Name (First, Middle, La	,						2. Date of Dea Month	Day	Ye	ar S	Time of I	Death	
	/Medi		ASHIQ HUSSAIN  4a. Facility Name (If not institution, given		·)		4b. City, Town,	or Location	of Dooth	MARCH		200 County of E		:08	$P^{M}$	
A.	Exami	ner	NATIONAL INSTI			ALTH	BETHE		or Death					Υ		
	Funeral		Social Security Number 6. 8			last birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of Birt (Month, Day				(State or	Foreign	
	Director		212-73-4238 Usual Residence of Decedent	ALIW ZUF	58	Yrs.		, louis		9/15/		8 P	akis	tan		
	yland now at		10a. State 10b. County		10c. Ci	ty, Town or Lo	ecation						10d.	Inside City	y Limits	
	a-f sh	cto	Md. Montgor	nery	Si	lver	Spring							1 ☐ Yes	2 <mark>∏</mark> No	
	death with the Maryland ms 23a or 28a-f show r must be notified at	Dire	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What	Country?			
	sath v is 23a nust l	eral	9619 McAlpine	Rd.	C		2090					kist				
36	72 hours after de natural", or item lical Examiner r	by Funeral Director	11. Marital Status  1 □ Never Married 3□ Warried  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Tyes 2 1 If Yes, Give Year or Dates:	?		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No			cify Yes or No- Rican, etc.)			merican I /hite, etc. Asia	·		
5-0036	2 hou atura cal Es	ted	15. Decedent's E	fucation		16a. Dece	dent's Usual Occu	pation		- 1	16b. Kin	d of Busine	ss/Indust	rv		
215	thin 7, e. an "n Medi	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	(Give	kind of work done DO NOT use retire	during mos ad)	st of workir	ng		a o. <u></u>	oo maaa	,		
21	led wi lygien her th nt, the	ပ္ပ	6			unen	nployed					ne				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. In procrant: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.	To Be	17. Father's Name ( <i>First, Middle, Last</i>					Sa	aid	(First, Middle, Jan						
Mar	d 2 sho th and ?7 is ma traum	S	19a. Informant's Name/Relationship (			1	ng Address (Stree								0.01	
	f Heal fem 2 other		Kosar Hussain  20a. Method of Disposition	/ daught		Place of Dispo	McAlp: sition (Name of matory or other pla	rne k		ate		ation - City			901	
E	Pages nent of nrt: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif				natory or other pla Cemete	1	3/20	0/07		ımaba			etan	
Baltimore,	permit. Pag Department Irrportant: I any injury c		21. Signature of Funeral Service Licer	-			. Name and Addre			Jniver					Scan	
8	30 E 8 9		1 /m //la	2th			11 Keni	nedy	St.	N.W.	Wash				0011	
			Approximate Interval disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate Interval Between on conditions are consistent or death.  Approximate Interval Between Onset and Death Seattle or conditions are consistent or death.													
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				ILUKE						3	Set and De		
	Examiner		<b>1</b>	Due to (or as	,	ue ice of):							3	J .	_	
		Je.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as		uence of):							3	M. W. 44	15	
	rate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C												
8760,	be ex sician burial			Due to (or as	a conseq	uence or):										
687	ificate g phys	edic		.d												
Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 🗆 Feta	ldeath 3□	Ectopic pregnanc	у			23	d. Date of	delivery Day	Ye		
P.O.	at the de by the a tached i	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9⊡Unknown	t time of d	eath 5∟	Other (specify) _					WOTH	Day	16	70.1	
ď.	res that igned b be deta	by Pr	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the ur	iderlying cause giv	en in Part I.		23e. Did tol	bacco us	ontribute	to the ca	use of dea	ath?	
ord	w require been sig should b	ed b	PENAL FAILURE							1 □ Y	es 2 🗷	No 3□	Probably	4 □Un	known	
or Vital Records,	e law r has be ie 2 shi	Completed								24a. Was a		24b. Were	autopsy f	indings av	ailable	
		Con								perfori	med? 2 🔀 No	death	es 2		ise oi	
Vita	siclan; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			3 DOA Oth			(Check only on						
ō	Phys er this eral dil	7. 70	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Inju	iry	ER/Outpatient 28b. Time of	3 DOA	4 ∐ Nu		e 5 Reside			pecify)			
ion	nding f ath. r: After e funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	28c. Injur Wor M 1	k? Yes 2∐1		3. 200000 110	on injury	boodiica				
Division	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica tely filled in by the funeral director; i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injuding, et	ury - At ho c. (Specify	me, farm, stre	eet, factory, office	3	28	Bf. Location (St City or Town	reet and n, State)	Number or	Rural Rou	ute Numbe	er,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical C	29a. Certifier (Check only one)  12 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examina	wledge, death tion and/or inv	occurred at the tirestigation, in my o	me, date an opinion, dea	nd place, an	nd due to the cad at the time, d	ause(s) a ate and p	nd manner lace, and d	as stated ue to the	cause(s)		
	To th To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		2	9d. Date	signed (Mo	nth, Day,	Year)		
	2		· of the	M.d,			D 64	307			3/13	1200	7			
			30. Name and address of person who	•	•		,									
	- CA	•	DAVID A. VITB 31. Date filed (Month, Day, Year) MAR 15 20	ERG 32_degistra			DRIVE,	BET	HESD	A, MAI	RYLA	ND 2	0892	2		
	Sta Registr	te ar	MAR 15 20	07 Section	_		14/2 2									

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (item 23a) (Type, Print) State MAR 2 9 2007 Registrar **ORIGINAL** 

			For	State of Ma	aryland			of Health a of Death	ınd Me	ental Hy		2 U U /	10065
			Registrar  1. Decedent's Name (First, Middle, Last)			007	imoaic	Or Death		2. Date of De	Reg. No.		3. Time of Death
	Physici	an	Donna Jean Hair	200						Month March	Day	Year 2007	7.00 7 M
	/Medic		4a. Facility Name (If not institution, give s				4b. City, To	wn, or Location of		"Ial CII		County of Death	7:00 A
	Examin	ier	2119 Nuttal Ave				Fda	500r.70			н	arford	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. las	st birthday)	If Under T			B. Date of Bi	rth		place (State or Foreign
	Director		219-34-4863	M 2⊠F	70	Yrs.	Months C	Days Hours	Min.	April			t Virginia
	2		Usual Residence of Decedent		10.00	-				1			Od. Inside City Limits
	arytar how	_	10a. State 10b. County		10c. City,	Town or Loc	cation						1 ☐ Yes 21⁄2 No
	Ba-f	Directo	Maryland Harford		Edger	wood	100 7: 0				10- 00		
	vith the		10e. Street and Number				10f. Zip Co	ode				izen of What Cou	ury r
	e 23e	Funeral	2119 Nuttal Avenue	2 12. Was Decedent B	Ever in II S	12 1/	210	40 at of Hispanic Orig	nin? (Spec	ify Ves or N	USA	14. Race - Ameri	can Indian
	p de de	nu	11. Marital Status  1 Never Married 2 Married	Armed Forces?		13. 4	Yes, specify	Cuban, Mexican	, Puerto Ri	ican, etc.)		Black, White,	
5	irs af	by F	3 ☐ Widowed 4 SpDivorced	If Yes, Give Year or Dates:		1	☐ Yes 25	No Specify:				Specify:	hite
5-0036	d within 72 hours after death with the Maryland spen. Jene. Than "natural," or items 23s or 28s-f show the Maryland at the Maryland Espaniter must be notified at		15. Decedent's Edu			16a. Deced	ent's Usual C	Occupation	a f warden	_	16b. Ki	ind of Business/In	
212	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	OO NOT use	done during most retired)	OF WORKING	9			
7		Completed	12			Self	Employ					ntal Pro	perty
2	be filed Ital Hygi ed other	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (	(First, Middle	e, Maiden	Sumame)	
<u>8</u>	should to and Ment marked umatic	<sup>2</sup>	Alva Burt Huffma							Alin			
Maryland	2 short		19a. Informant's Name/Relationship (Ty				•					or Town, State, Zij	Code)
	l and lealth im 27 iner ti		Elizabeth French 20a. Method of Disposition	/ Daughte				l Ave.,	Edgew Da			LO40 ocation - City or T	own State
altımore,	Pages nent of thint: if ite		1 ⊠Burial 2 ☐ Cremation 3 ☐ R	emoval from State			sition (Name natory or othe						om, claic
	t. Pa rtmer rtant rjury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Rest1		m. Gard		3/28/20			ale, MD Home, P.A	
R	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Furieral Service License	1111	111			inia Avenu	-				<b></b>
			23a. Part1 Enter the disease, or compli	eations that caused	the death.							21302	Approximate
ı			shock, or heart failure. List only or Immediata Cause (Final	ne cause on each lir	ne.	1/1/1	110	In PAPA	11/	0/1/	100	TenA	Interval Between Onset and Death
).	Physician /Medical		disease or condition resulting in death)	Due to (or as	a conseque	Orug	19/	U SINSII	JU	INF	MC	1101	
п	Examiner					,							
9	n ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):							
13	ecuter ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
, Q	ate be executed hysicien and the burial-transit	Ü	1050thing in death) Last	Due to (or as	a conseque	ence or):							_
98/60	certificate be executed nding physicien and use as the buriat-transit	dicai		1									
× e	eath certific attending pl	/Me	IF FEMALE:	3c. If yes, outcome	of pregnance	су						23d. Date of deliv	erv
Box	atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic preg Other (spec					Month	Day Year
Ö	oy the	hysi	9 Unknown	9⊡ Unknown									
v, J	law requires thet the de as been signed by the 2 should be detached	by P	Part II. Other significant conditions con	ntributing to death b	ut not result	ting in the ut	nderlying cau	se given in Part I.		23e. Did	tobacco	use contribute to	he cause of death?
ğ	quire an sig uld b									1 🗆	Yes 2	□No 3□Pro	bably 4 Nnknown
ecords,	awre	plet								24a. Wa	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
<b>T</b>	Physician: The lav this certificete has al director, page 2	Completed								per 1 Yes	formed?	death?	20 No
Vital	ortifica ctor,	Be	25. Was case referred to medical examiner?					26. Place	of Death	(Check only	one)		
	hysic his ca Il dire	2	1 ☐ Yes 2 No	lospital: 1 ☐ Inpatie			t 3□ DOA	<del></del>				6 ☐Other (Speci	fy)
ב	ding Ph th. After th funeral	 0	27. Manner of Death  1 ☑Ñatural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year) 2	28b. Time of Injury		Work?		8d. Describe	o how inju	ry occurred	
<u>s</u>	Attending Physician: r death. ector: After this certific by the funeral director,	cat	Accident investigation 3 Suicide 6 Could not be	28a Place of Init	ive. At hom	no form etc	M factors	1 Tyes 2 I		8f Location	(Street ar	nd Number or Rui	al Route Number
Division of	or A after Direction by	Certification;	4 Homicide determined	28e. Place of Injubulg		ne, laim, sir	eer, raciory, c	onice			own, State		arriodio ridinosi,
	Hospitel 24 hours 8 Funerel I tely filled			sicien: To the best									
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exami	ner: On the basis of and manner sta		on and/or in	vestigation, in	n my opinion, dea	ith occurre	d at the time	e, date an	d place, and due	to the cause(s)
	To the To the Complet	×	29b. Signature and title of certifier	1 11	ml.	11	29c. l	License number	200.	100	29d. Da	ite signed (Month	Day, Year)
)			/ hames	A. Dun	40.	MII		114-	186	10		2/23/	7
	13		30. Name and address of person who co	ompleted cause of d	death (Item 2	23a) (Type,	Print)	11/1/10	11/1	all	ilall:	/ /IN	2079.
			31. Date filed (Month, Day, Year)	32 Registr	rar's Signatu	7/ 7	2001	14 UNIO	11	00,1	T (I. W)	1 rungs	(10/10)
	St: Regist	ate rar	MAR 2 9 2007	Real	K	board	20				/	/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 63 Day Year **Physician** 1507 M SEORGE JOHNSON Ó 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BAITIMORE UNIVERSITY OF MARY LAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/14/1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 78 Hours 561-38-1294 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Director 1 ☐Yes 2 X No MD KENT CHESTERTOWN 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5165 DEEP POINT DRIVE 21620 USA Funeral 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: WHITE Specify: Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ESTATE MANAGER FINANCIAL permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important; if item 27 is marked any injury or other 27. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELDRIDGE REEVES FENIMORE JOHNSON JANET MACLAREN DARBY ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. TYLER JOHNSON/SON P.O. BOX 2600, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ST. PAUL'S CEMETERY 03/17/2007 CHESTERTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee Ellows 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMUNIA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician a Box 68760, Physician/Medical attending p 33 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 🗆 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 FAILURE 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page performe certificate 1☐ Yes 2000 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tes 2 No 1 [9] Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: ospital or Attending I 1 Natural Injury 5 ☐ Pendina within 24 hours after to...

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 AV417635K17432 2007 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + KolDolski STREET 295 GREENE BALTIMORE DAFRA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of	Maryland		artmen <i>rtificati</i>					giene Reg. No.	200	7	100	67
			1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea		. V		3. Time of 0	Death
	Physici /Medic		Kyong Soon	Jacks	on						Month March	Day 1.7	Yea 200		7:15A	M /
Ì	Examin		4a. Facility Name (If not institution 3947 Old Wash					Town, or aldo	Location o	of Death			County of De	ath		
	Funeral Director		5. Social Security Number 215-06-3651	6. Sex 1 ☐ M 2 🌠 F	7. Age (In yrs. la 58		If Under Months	1 Year Days	ff Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day May 20	1948		Birthplac Country Outl	ce (State or 1) 1 Kon	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							100	I. Inside City	v I imits
	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "naturel", or items 23s or 28s-f show event, the Medical Examinar must be notified at	5	MD Char			laldor								100	1 TYes	-
	28e-	Director	10e. Street and Number		, , , , , , , , , , , , , , , , , , ,	aldol	10f. Zip	Code				10g Citi	zen of What	Countr		X
	3s or		3947 Old Was	hington Ro	ad				602				USA			
	ms 2	Funeral	11. Marital Status		dent Ever in U.S		Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No-	.	14. Race - Ar			
9	or its		1 ☐ Never Married 2 🔀 Mar	nied 1 Tes	2 No					ı, Puerto I	Rican, etc.)		Black, W	hite, et	o.	
8	irel',	d by	3 Widowed 4 Divorced	ff Yes, Give Year or Da	tes:		1□ Yes 2	XNO	Specify:				Specify:	Kore	ean	
Maryland 21215-0036	72 h "natu	Completed		nt's Education ist grade completed)		(Give	dent's Usua kind of wor	k done o	<i>turi</i> na mosi	t of workit	n <i>g</i>	16b. Ki	nd of Busines	ss/Indu	stry	
12	within ene.	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	Homer						11.			
D 2	e filed within al Hygiene. other then '	ပိ	17. Father's Name (First, Middle,	Last)			Tromer	nake.		r's Name	(First, Middle,	Maiden		ome		
aŭ	d be Botal Ked o	To Be	Mong Ku Chin									Wald Of F	ourname,			
N.	2 should be and Mental is marked (	-	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a			Chin I Route Numbe	ar, City or	r Town, State	. Zip C	ode)	
	nd 2 alth a 27 is r trau		St. Clair Jack	son/Husban	d						ad,Wald			0602		
re,	tem Item othe		20a. Method of Disposition			ace of Dispo	sition (Nan	ne of			ate		cation - City			
E	Page nent c int: If iry or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			ryland				.3/20	0/07	Che1	tenham	,Ma	rylan	d
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic e ance.		21. Signature of Funeral Service	E-Gul.	M00945	1		RT-E	CHOLS	FUN	ERAL HO					
			23a. Part1. Enter the disease, o	r complications that ca	used the death.	Do not ent	er the mode	of dying	ary's g, such as	Ave cardiac o	<ul> <li>La P1</li> <li>r respiratory ar</li> </ul>	ata,	MD 20	<del>)646</del>	pproximate	,
	Physician		shock, or heart failure. Lis fmmediate Cause (Final	only one cause on ea	ch line.		1	_	16	( )					nterval Betwonset and De	
and a	/Medical		disease or condition resulting in death)	a. Due to (c	or as a conseque	ence of);	1	-1	V 1	V						
	Examiner		O second the first consider			·										
	n =	ner	Samentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (a	r as a conseque	ence of):										
	nd	Examiner	that initiated events	с												
90,	oe exe	EX	resulting in death) Last	Due to (o	r as a conseque	ence of):										
8760,	the death certificate be executed y the attending physicien and sched for use as the burial-transit	dicai		d										-		
9 X	eath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outc	ome of pregnan	CV										
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 Fetal on the at time of dea	death 3	Ectopic pro					2	23d. Date of o Month	Da	ay Ye	ear
o.	that the de ned by the a detached t	ysl	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknov		0	3 0 11101 1301	JOIIY)								
<u>.                                    </u>	d b	by Pi	Part If. Dther significant conditi	ons contributing to dea	ath but not resul	ting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute	to the	cause of de	ath?
rds	n sign	D D									1 🗆 Y	'es 2[	]No 3□	Probab	fy 4 Cur	nknown
00	s been si	Completed									24a. Was a	an	24b. Were	autopsy	y findings av	vailable
R	The law rate has by page 2 st	E									autop perfor	med?	prior to death	?	letion of car ⊒ No	use of
ita	ician: Th certificate ector, pag	0	25. Was case referred to medica	ı					26. Place	of Death	1 Yes					
<b>&gt;</b>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ∏ No	Hospital: 1 ☐ In	patient 2 E	R/Outpatier	t 3 DO	A Othe	·-		ne 5. <b>∏X</b> Resid		Other (Sp	oecify)		
0	ng Pl		27. Manner of Death 1 ☑Naturaf 5 ☐ Pendii	28a. Date of (Month	Injury 2 Day Year)	28b. Time of Injury	21	Bc. Injury Work	at ?	2	8d. Describe h	ow injury	occurred			
sio	uttendi death. ctor: A / the fu	catl	2 Accident investi	gation			М		/es 2 □f	No						
Division of Vital Records,	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 200. Flace	of Injury - At hong, etc. <i>(Specify)</i>	ne, farm, str	eet, factory	, office		2	8f. Location (S City or Tow	Street and m, State)	d Number or	Rural F	loute Numb	ιθ <i>Γ</i> ,
	To the Hospital or Attending Physician: within 24 hours atter death with 17 to the Funeral Directors After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)  1. Certifyii 2 Medical	ng Physician: To the base	sis of examination	ledge death on and/or in	recurred a	at the tim in my op	e, date and inion, deat	d place, a	nd due to the o	ause(s) date and	and manner place, and d	as state ue to th	ed. e cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifie	1	1 400	1	296	License	number		0.5	29d. Date	e signed (Mo	nth, Qa	y, Year)	
)		-	- MAI	/ Ship		V		) "	NS	06	124	- 2	117	21	0	
1	81h		30 e a ad ess of rson	who co leted cause	of death (Item :	23a 17 100	) N	11	).	JA	200	N	- M	O.	105	02
	Sta Registr		31. Date filed (Month, Day Year,	4 2007 32.	distrar's Signatu	* A	men	,	•					•		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 March 13, Physician 4:45 P Hugh Nelson Johnson, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Ellicott City Health & Rehab. Center Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Y Oct 11, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1928 New York Hours Months **™** M 2□F 78 081-20-8342 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Howard Ellicott City Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3000 N. Ridge Road 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White If Yes, Give Year or Dates:1947-51 þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Financial Manager Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental Hiant: If item 27 is marked other. Hugh Nelson Johnson, Sr. Agnes Marie Lukacs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peter Douglas Johnson/son 5435 The Bridle Path Columbia, MD 21044 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Crematory 03/15/07 Beltsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a.Sepsis /Medical Due to (or as a consequence of): Examiner b.Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit c. Advanced Alzheimer's Disease and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 ☐ Yes 2 XNo 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mannes of Death 28c. Injury at Work? After Injury 1 Naturai 2 Accident 5 Pending 1 Tes 2 No investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier & Glund D30641 March 14, 2007 + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi, M.D. 201-109 Back River Neck Rd. Baltimore, MD 21221 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 200 Same . Registrar

			For State Registrar	State of Mai	ryland			of He		nd Men		iene	007	10069
	Physicia		1. Decedent's Name (First, Middle, Las Doris M. Kin								Date of Deat Month arch 1	Day	Yeer 007	3. Time of Death 10:43 A M
).	/Medic Examin	er	4a. Facility Name (If not institution, give Charles County Nur		ab. (	Center		Town, or Lo		Death			ounty of Deat harles	h
	Funeral Director		210-10-3030	ex 7. Age ☐ M 2 ☑ F 83	(In yrs. la	ast birthday) Yrs.	If Under Months		f Under 24 Hours	Min.	Date of Birth Month, Day, Luary	Yeer)	9. Birti 924 Ma:	hplace (Stete or Foreign untry) ryland
	f ehow	ō	Usuel Residence of Decedent  10a. State 10b. County  Maryland Charles		10c. City	Town or Lo								10d. Inside City Limits 1 Tyes 2 No
	with the Na or 28a-	I Directo	10e. Street and Number 5310 Doris Drive			waldo.	10f. Zip	Code 0601			1	0g. Citize	en of What Co	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygene.  Is marked other than "naturel; or items 23s or 28s-f show sematic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Oivorced	12. Was Decedent Ex Armed Forces? 1 ☐ Yes 2 € No If Yes, Give A Year or Dates:			Vas Deced Yes, spec		panic Origin Mexican, f Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)		I. Race - Ame Black, White Specify: W	
Maryland 21215-0036	within 72 hounders.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+	•)	16a. Deced (Give life. L	kind of wo DO NOT u	rk done dui	on ring most o	of working			e of Business	
land 2	e filed Il Hygi other	To Be Co	12 17. Father's Name (First, Middle, Last) Edwin Moore Tucke				<u>J</u>				irst, Middle, I Llia W	Maiden S		
	of 2 should had had had had had had had had had ha		19a. Informant's Name/Relationship ( Roxanne Gartland-			1						ALCO DE LOS DE	Town, State, 2	Zip Code)
Baltimore,	permit. Pages 1 and 2 should by Opportment of Heelih and Menta Important: If item 27 is marked any injury or other treumatic and <u>once.</u>		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	Cé	lace of Dispo emetery, cren sidence	sition (Nar natory or o	ne of		Date		20c. Loc	ation - City or	Town, State Maryland
Balti	Depermit. Depertment importation any injure.		21. Signature of Funeral Service Licer	isee	)945	Å22	Name ar rehar				al Hom			
	Physician		23a. Part1. Enter the disease, or com shock, or heert failure. List only Immediate Cause (Final disease or condition	one cause on each line	a	Do not enti +as+a	er the mod	le of dying,	such as ca	ardiac or re	spiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	uence of):								
	scuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or as a										
8760,	icate be executed physicien and s the burial-transit	cal	leading in death, East	Due to (or as a	consequ	Jence Oi):								
Division of Vital Records, P.O. Box 68	Hospital or Attending Physician: The law requires that the death certifica 24 hours effer death. Funerel Director: After this certificete hes been signed by the attending pholely filled in by the funeral director, page 2 should be detached for use as it liely filled in by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 Fetal	death 3	Ectopic p					23	3d. Date of de Month	livery Day Year
rds, P.	quires that n signed build be deta	ρ	Part II. Other significant conditions.  Atrial fi	contributing to death bu	t not rest	ulting in the u	nderlying o	teause given	in Part I.	_		1	/	o the cause of death?
Reco	sician: The law rer s certificete hes bee irector, page 2 sho	Completed	Cervica	( Canc	00						24a. Was a autop perfor 1 \( \text{Yes} \)	sy mekd/?	24b. Were a prior to death?	utopsy findings available completion of cause of
/ita	Physician: The this certificate he	Be	25. Was case referred to medical examiner?	Manitali							check only or			
on of \	ing Physi After this c funeral dire	P	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injun (Month, Day		ER/Outpatier 28b. Time o Injury		28c. Injury a Work?		280	5 Resid		Other (Spe	ocify)
Division	or Attended by Director:	Certification;	2 Accident investigatio 3 Suicide 6 Could not be determined	9 Place of frie	ry - At ho	ome, farm, str					Location (S City or Tow		Number or A	ural Route Number,
	To the Hospital or Attending I within 24 hours efter death.  To the Funerel Director: Atter completely filled in by the funer	Medical C	29a. Certifier (Check only one)	nysician: To the best o miner: On the basis of and manner stat	examina	wiedge, daat tion and/or in	h occurred vestigation	at the time	data and nion, death	ulace, and occurred	due to the cat the time, o	date and	and manner a place, and du	s stated e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier  R. Lind	Lwant			'	c. License	ser 1	16/6		Ma	= 5 6	th, Day, Year)
(	N3.7		30. Name and address of person who	completed cause of de	eath (Item	n 23a) (Type,	Print)	E R.	SINI	DHU	ANT	nA	RYLA	~2
	St: Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 6	32. <del>Jegistra</del>	ır's Signa	ture	and )	,						

			5	State of Ma	aryland	d / Depa	ırtme	nt of H	lealth	and Me	ntal Hy	giene		
A	mend it	em	1 - State Registrar #5 per FH/t								-	Reg. Nd	and the state of	10070
			Decedent's Name (First, Middle, La.	st)	_0//0	110				2	2. Date of De.	ath Day	Year	3. Time of Death
	Physici /Medic		Beverly Ann Ki	nney						1	March		2007	7:43 р м
t.	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City	, Town, o	r Location	of Death		4c.	County of Dea	ath
			32152 Old Ocean (	City Road					sburg				licomic	
	Funeral Director		213-56-0/11	ex 7. Age	56	ast birthday) Yrs.	Months	er 1 Year Days	If Under Hours	Min.	Date of Bird (Month, Da)		9. Bi	rthplace (State or Foreign country) Laware
	and will		Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Loc	cation							10d. Inside City Limits
	Manyi f sho	ō	MD Wicomi	00	Do	rsonsb	1120							112€Yes 2 □ No
	28a	rec	10e. Street and Number		La	1 201120		ip Code				10g. Cit	zen of What C	country?
	3a o	Funeral Director	32152 Old Ocean (	ity Road				2184	9			U.	S.A.	
	deat ms 2	ner	11. Marital Status	12. Was Decedent I	Ever in U.S	S. 13. V	Vas Dec	edent of H	ispanic Or	igin? (Speci	fy Yes or No can, etc.)	-	14. Race - Am Black, Wh	
9	or the	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 🖾 N If Yes, Give	10				Specify.		oan, o.c.,		Specify:	white
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show event, I're Medical Evan fra must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:										
<u>.</u>	s filed within 72 t 1 Hygiene. other than "nati	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Deced	ent's Us kind of w	ual Occup	ation during mos	st of working	,	16b. K	nd of Busines:	s/Industry
12	withir ene. then	m	Elementary/Secondary (0-12)	College (1-4or 5	+)			make					Home	
0 0	filled Hygi ent, t		17. Father's Name (First, Middle, Last,	)			Home	- Incarco		er's Name (	First, Middle,	Maiden		
an		To Be	Noble Wooleyhand						Mar	tha L	arimor	e		
Maryland	d 2 should be th and Mental 77 Is marked o traumatic eve	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Addres	ss (Street	and Numb	er or Rural I	Route Numbe	er, City o	r Town, State,	Zip Code)
	Tra Tra		Rodney C. Brown	(Son)		28249	Adk	ins	Road	Sai	lisbur	y, M	D 218	01
ē,	os 1 and of Healt item 2 other		20a. Method of Disposition		20b. Pt	lace of Dispos	sition (Na	ame of other plac	(e)	Dat			cation - City o	r Town, State
Ĕ	Pages nent of int: If it iry or o		1 ☐ Bunal 2 K Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		1	natory				3-15-	2007	De:	lmar, D	elaware
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licer	1600		22.	Name a	and Addres	ss of Facili	Home				
<b>m</b>	89 2 2 3		19 will	2						treet	De1	mar,	DE 1	9940
П			23a. Part1. Enter the disease, or com shock, or bear failure. List only	plications that caused one cause on each lin	the death	. Do not ente	er the mo	de of dyin	g, such as	cardiac or	respiratory ai	rrest,		Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	. 89	000	hagea		Con	cer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):						-		
	Examiner	_	Sequentially list conditions,	b										
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):								
	ate be executed hysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of):								
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	cate phys s the			d										
	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of de	alivery
. Box	death atter	ciai	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic     Other (s	pregnancy specify)	'				Month	Day Year
o.	t the c by the achec	hysi	9 Unknown	9 Unknown							· · · · · · · · · · · · · · · · · · ·			
۵.	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	by P	Part II. Other significant conditions of	ontributing to death b	ut not resu	ılting in the un	derlying	cause giv	en in Part	l.	23e. Did t	obacco u	ise contribute	to the cause of death?
Vital Records,	w require been sig should b										10,	res 2	□No 3☐F	robably 4 Unknown
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Ä	The lav	m <sub>o</sub>									perfo	rmed? 2 No	death?	
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	nysic nis ce I direc	ToE	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 🗆 i	ER/Outpatient	t 3 🗆 🗅	Oth Oth	er: 4 🗆 N	ursing Home	5 Aesid	dence	6 □Other (Sp	ecify)
0	ding Phy h. After thi funeral c		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	y Year)	28b. Time of Injury		28c. injur Wor	y at k?	28	d. Describe I	now injur	y occurred	
<u>s</u>	Attending Physician: In death. Sector: After this certification by the funeral director.	cati	2 Accident investigation 3 Suicide 6 Could not b				М		Yes 2					
Division of	l or Attencafter death Director: I in by the	Certification:	4 Homicide determined		ury - At ho c. (Specify	me, farm, stre	et, facto	ry, office		28	City or Tox			Rural Route Number,
السا			29a, Certifier 1 Certifying Pt	nysician: To the best	of my kan	wledge don't	0001:55	d at the time	ne data c	nd place an	d due to the	cause/s	and manner	es stated
	To the Hospita within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examinat	ion and/or inv	estigatio	n, in my o	pinion, de	ath occurred	at the time,	date and	place, and du	e to the cause(s)
	o the	Med	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Da	e signed (Mor	oth, Day, Year)
	- 2 - 2		A	MO				0	5412	77		3	115/0	7
١	100		30. Name and address of person who		eath (Item	23a) (Type. I	Print)	,,,		,				
١	W.		11 122.06	ND 100	-	ower		Se-	lisbu	ry	mo	2	1804	
47	Sta	te	31. Date filed (Month, Day, Year)	32. Registra						0				
	Registr	àr	MAR 16	2007										

ORIGINAL

		•	For State Registrar	State of M	aryland		artmen			ind M		giene Reg. No.	2007	10071
	1.00	-	1. Decedent's Name (First, Middle, Last	)		-					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		Maynard W. Lay	ne						1	larch	7	2007	7:00 p <sup>M</sup>
7.	Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or I	Location o	f Death		4c.	County of Deat	h
			Kensington Nursin  5. Social Security Number 6. Se		ab. Ct		Whea		If Under 2	24 Hrs	9. Data of Bir		ntgomer	
	Funeral Director		18	X M 2□F 7. A9	92	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Mar. ]	y, Year)	Co	hplace (State or Foreign puntry) VA
		E .	578-07-1439 Usual Residence of Decedent		,						rial. I	., 17	13	VA
	how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	e Ma	Director	MD Prince (	George's	L	anhan	1							1. Yes 2 No
	vith th	Dire	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What Co	ountry?
	s 23s	rai	6933 Lamont Dr.	12. Was Decedent	Free in II C	10.1		0706	a a a i a O dia	i=2 (C==		U.S.	A . 14. Race - Ame	don lodin
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marned	Armed Forces?		13.1	f Yes, spec	arty Cuban	, Mexican	, Puerto F	cify Yes or No Rican, etc.)	)-	Black, White	
036	urs al	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2⊠ No	Specify:				Specify: Wh	nite
2	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	dent's Usua kind of wor			of workin	ia.	16b. Kir	nd of Business/	Industry
2	nithin Ben	nple	Elementary/Secondary (0-12)	College (1-4or		life. i	DO NOT us	e retired)	,,,,,g,,,,,oo,	or working	9		a 1.	
2	led w tygier her th		12 17. Father's Name (First, Middle, Last)			Accou	intant		10 Matha	eta Atama	(Cima Adidde		. Gov't	
and	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is marked other then "natural; or items 23a or 28a-1 show aumatic event, it a Medical Examinar must be notified at	Be									(First, Middle	, машеп	Sumame)	
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<u>8</u>	Ith ar Ith ar 27 ie r trau	2 1	Virginia Layne/W				•	•			n, MD 2			
re,	s 1 ar	1 19	20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Nan	ne of	1	D	ate	20c. Lo	cation - City or	Town, State
Ē	Pages nent of int: if it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			Linc				ar.1	3,2007	Bre	entwood	, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should b Department of Health and Mente Important: If item 27 is marked eny injury or other traumatic e once.		21. Signature of Funeral Service Licens	600 A		22	. Name an	d Address	of Facility	y Ft	. Linc	oln I	F. H.	
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140 1731			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused ne cause on each li	the death. ne.	Do not ent	er the mode	e of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	PN	EUM	ON	IA						Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):								
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Вох	death certific e ettending p id for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal d	eath 3	Ectopic pr					2	23d. Date of del	ivery Day Year
	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of dea	th 5 [	Other (spe	ecify)						54)
۵.	that it		Part II. Other significant conditions co	ntributing to death b	ut not resulti	ing in the u	nderlying ca	ause giver	n in Part I.		23e. Did	obacco u	se contribute to	the cause of death?
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ta	sician: Th certificete rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 Yes	2.☑No one)	1 101	21 140
	S 50	To B	examiner? 1 Yes 2 No	Hospital: 1 🗌 Inpatio	ent 2 🗆 EF	R/Outpatier	it 3□ DD	A Other	4 Nui	rsing Hom	ne 5 ☐ Resi	dence 6	6 □Other (Spe	cify)
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<u>s</u>	Attending ir death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	One Disease (In			М		es 2 🗆 h		Of Lanatina (	C4	/ N 0	
Division of	i Ditto	Certification:	4 Homicide determined	28e. Place of In building, et	c. (Specify)	ie, tami, str	eet, factory	, office		2	City or To			ural Route Number,
	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu		29a. Certifier 1 Certifyin 1 Phy	sician: To the hest	of my knowle	edos desti	n unquiried i	et tha time	: date and	fulace a	nd due to the	counstal	and marrier as	statuc
	e Ho	edical	(Check only 2 Medical Example one)	iner: On the basis of and manner st	f examinatio	n and/or in	vestigation,	in my opi	nion, deat	th occurre	d at the time,	date and	place, and due	to the cause(s)
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}													1810	
9	(4)		30. Name and address of person who c	ompleted cause of	leath (Item 2	23a) (Type,	Print) I	105	200	VVI	115	M	1	0053
			31. Date filed (Month, Day, Year)					K	-00			- 1	ر ح	(3)7
	Sta Registi		MAR 13 2007	been !	ar's Signatu	all!	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Ам 7:45 2007 March 8, 4c. County of Death 4b. City, Town, or Location of Death Prince George's Lanham 3. Date of Birth (Month, Day, Year) 08/03/1937 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Days Months Hours 1 XM 2□ F Yrs. West Virginia 69 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 XYes 2 No Lanham Prince Georges 10g. Citizen of What Country? 10f. Zip Code

**Physician** /Medical Examiner

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If them 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at permit. Pages Department of I Important: If Its any Injury or o

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

sician and burial-tran physician the as attending ; the detached has certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this

that the death certificate be executed

Box 68760,

Records, P.O.

Division or Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIRA 31. Date filed (Month, Day, Year) State Registrar

3 2007

VENKAMR AMAN KD 32. Registrar's Signature

ORIGINAL

David Edwin Meadows 4a. Facility Name (If not institution, give street and number) 9331 Washington Boulevard Social Security Number 235-54-8580 Usual Residence of Decedent 10a. State Director Maryland 10e. Street and Number USA 20706 9331 Washington Boulevard Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha E. Wallace Jacob Benjamin Caudle Meadows P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9331 Washington Boulevard Lanham, MD 20706 Doris M. Meadows/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/09/2007 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) Huntts Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee M. P.Knis 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 MONTH Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death Certification: 1 Natural 5 ☐ Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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			1 - For State Registrar	State of Ma	aryland /	Certific				g. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, La	Kerson					2. Date of Death Month	LO 200°	3. Time of Death
	Examir		4a. Facility Name (If not institution, giv Baltimore Rehabi	street and number)	+- 1 .1	/ 4b. C		Location of Death		4c. County of De	
							altimo			Baltimor	
	Funeral Director		195-12-4593	ex 7. Ag M 2□F	e (In yrs. last I	Yrs. Mont	hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/26/1	918 Pe	Sirthplace (State or Foreign Country) nnsylvania
	anyland show	10	Usual Residence of Decedent  10a. State 10b. County			own or Location					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Scto	Maryland Anne Ar	unde1	David	sonvill					
	with t	Öİ	10e. Street and Number				Zip Code			g. Citizen of What	•
	e 23	rai	573 Jamestown Cou	,	Supplied I.I.S.		1035	Januaria Osiaia? (Co		United St	ates merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Important: If Item 27 Ie marked other than "natural", or Iteme 23a or 28a-f show important: If Item 27 Ie marked other than "natural", or Iteme 23a or 28a-f show thip rightly or other traumatic avent, the Medical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 文 Yes 2 日 If Yes, Give Year or Dates:	No	1 □ Ye	specify Cuba specify No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wi	hite, etc.
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Maryland	2 should be filed with and Mental Hygiene. Ie marked other tha sumatic avent, the s	F	19a. Informant's Name/Relationship (	Type, Print)	15	9b. Mailing Addi	ess (Street			City or Town, State	, Zip Code)
Š	Ith at 27 le		Rosalind M. Morto			_					vland 21035
ē,	f Heal f Heal frem otha		20a. Method of Disposition		20b. Place	of Disposition (	Name of		Date 2	20c. Location - City	or Town, State
E O	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			s Crema			1/2007	Edgewater	, Maryland
Baltimore,	Departm Departm Importal any injui		21. Signature of Funeral Service Licer		1			s of Facility Ge	orge P. 1		eral Home
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	Physician and /Medical Examina and step physician and as the purial-transit	edical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as Due to (or as c.	von a consequence a consequence	e of):	rter	y Dis	ease		Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1  Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	ith 3 ⊟Ectopi 5 ⊟ Other	c pregnancy (specify)			23d. Date of o	delivery Day Year
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Vit	iciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:			DOA Oth	20	th (Check only one		
of	Phyaician: this certificatal director,	. To	1 ☐ Yes 2 ☐ No  27. Manger of Death	28a. Date of Inju		Outpatient 3  Time of	DUA	4   Nursing n	ome 5 Reside	nce 6 Other (S	Decify)
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Division of Vital	To the Hospitel or Attending Phyship in A bours alter death.  To the Funaral Director: After the completely filled in by the funeral	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inj	jury - At home, c. (Specify)				28f. Location (Str City or Town		Rural Route Number,
	ne Hospit 24 hour ne Funare	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best niner: On the basis o and manner st	t examination :	lge, death occur and/or investiga	red at the tin tion, in my o	ne, date and place oinion, death occu	and due to the ca rred at the time, da	use(s) and manner ite and place, and d	as stated. tue to the cause(s)
		M	29b. Signature and title of certifier	Wiih	M	M.D.	29c. Licenso	1365		d. Date signed (Mo	onth, Day, Year) D , 2007
	16 HUA		30 Name and address of person who	completed cause of c	death (Item 23a	a) (Type, Print)	och 1	Raven B			som, MD, ZIZIP
100	Sta	ite	31. Date filed (Month, Day, Your)	32. Registr	a Signature	Žo.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anthony Paul Mowery MARCH 14 2007 11:40PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DORCHESTER DORCHESTER GENERAL HOSPITAL CAMBRIDGE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 1, 1958 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 19M 20F 49 Mary Land 213-70-7924 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other then "naturel", or Iteme 23a or 28a-f ehow treumatic event, the Madical Examinar must be notified at Marvland Dorchester Cambridge 1 Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2405 Canterbury Drive 21613 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Š White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Ie marked other then "r Heating/ Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 HVAC Specialist Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Michael Mowerv Josephine Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tre once. Julie C. Mowery/Wife 2405 Canterbury Dr., Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Peges 1 tment of h 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State MidShoreCremationCenter 3/16/2007 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Curran-Bromwell Funeral Home, P.A.
308 High St., Cambridge, MD 21613 21. Signature of Funeral Service Licensee Wester Fler 23a Part. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart alture. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Thespiratur **Physician** WEEKS /Medical Due to (or as a consequence of): Examiner hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physiclen and for use as the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has tirector, page 2 s autopsy performed' 1 Yes 2 1 Yes 2 No Division of Vital After this certification funeral director, i or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending efter death. I Diractor: Aft investigation 1 Yes 2 No 2 ☐ Accident the f 6 Could not be 3 Suicide Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours efter or To the Funaral Dirac completely filled in by 4 Homicide To the Hospitel 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lugen 0 1cm 30. Name and address of person who completed cause of death (ftern 23a) (Type, Print) 20 503 Venmer

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Resistrar's Signature

			For State Registrar	State of Marylan		rtment			nd Me	, ,	giene Reg. No.2	0.7	10075
200		- 7	negistrar     Decedent's Name (First, Middle, Last)							Date of Dea	ath		3. Time of Death
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No.	/Medic		4a. Facility Name (If not institution, give s			4b. City, 7	Fown, or	Location of			4c. County		
-	EXCIIII		Union Hospital			E13	ktor	ì			Cec	i1	
	Funeral Director		222-20-9656	M 2□F 7. Age (In yrs. 73	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. Ju	Date of Birtl (Month, Day 11 y 2	, 1933	9. Birth Cou	place (State or Foreign ntry) PA
	≱ud M		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	cation							10d. Inside City Limits
	faryla sho	ō	MD Cecil		1kton								1 ☐ Yes 2 No
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	with 3a or t be	Funeral Director	800 Little Eq	ypt Rd.				921				U. S	S.A.
	ns 2: mus	era		2. Was Decedent Ever in U	.S. 13. W	Vas Deced	ent of His	spanic Orig	in? (Specif	y Yes or No- can, etc.)	14. Race		can Indian,
(0	ifter of	Ξ	1 □ Never Married 2 ★ Married	Armed Forces? 1X Yes 2 No					, Puerto Rio	can, etc.)		k, White <sub>r:</sub> Whi	
03	ours arright.	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 195	0's '	I□Yes 2	2 LINNO	Specify:			Specify	. *****	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decede	lent's Usua kind of wor	l Occupa k done d	tion uring most	of working		16b. Kind of Bu	isiness/Ir	ndustry
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and	be fi	Be	17. Father's Name (First, Middle, Last)  Arthur Monger							iae L		ic)	
ž	d Mer narke	မ	19a. Informant's Name/Relationship (Type	o Print)	19h Mailine	a Addrass	(Street a				er, City or Town,	State 7	n Code)
Maryland	d2st than 7 is n traun		Beverly Monger/		1	-					1kton,		21921
	ges 1 and 2 t of Health if Item 27 I		20a. Method of Disposition	20b.	Place of Dispos	sition (Nam	ne of		·		20c. Location -		
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e C	law las b	ple								24a. Was	an 24b.	Were aut	opsy findings available ompletion of cause of
E		ပ္ပ	1960									death? 1 ∐ Yes	2 No
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'n	ding P	i.i	27. Manner of Death 1  Natural 5 Pending	(Month, Day Year)	Injury	M 2	8c. Injury Work	rat ? /es 2∐f		a. Describe r	now injury occur	rea	
Division or Vital Records,	Attendi death. ctor: / y the fi	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At h	ome farm stre			162 5 1		f Location (S	Street and Numb	er or Ru	ral Route Number,
<u>≥</u>	or A after ( Direction by	ij.	4 ☐ Homicide determined	building, etc. (Speci	fy)	oci, idolory	, onioc		201	City or Tov		07 07 710	ar roots rambon
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a, Certifier 1 Certifying Phys	sician: To the best of my kn	owledge, death	n occurred	at the tin	ne, date an	d place, an	d due to the	cause(s) and ma	anner as	stated.
	e Hos 24 h e Fur	edical		ner: On the basis of examin and manner stated.									
	ro the vithin rough complete c	Me	29b. Signature and title of certifier			290	. License	number			29d. Date signe	d (Month	, Day, Year)
	,- > 0		> and do . <	mi			000	233.	12		3.14	1. 20	07
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, F								
e	20		1 8 1 4	no 118		th s	t -	Su	ite	313	Zikto.	1. m	021921
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	local	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2:05 P M 2,2007 march Richard John McNeil, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner erry Poin VA Maruland Healthlare Date of Birth (Month, Day, Year) 'eb. 20,1923 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 84 217-16-0567 California Feb. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 1 No Maryland Colora Cecil 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a or 710 Rowland Road 21917 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1943-45 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No ρ Specify: White 3₺ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 sho Id be filed within 7 th and Nental Hygien... 7 is marked other than "n Elementary/Secondary (0-12) Eight Years College (1-4or 5+) Self-Employed Truck Driver Trucking/Transport 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Harry McNeil Florence Meck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a.
Important: If Item 27 is any injury or other trauonce. Richard J. McNeil, Jr. 9 Orchard Drive, Port Deposit, Maryland 21904 (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □Cremation 3 □Removal from State Harmony Chapel Cemetery Liberty Grove, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 03/15/07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months arcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran Due to (or as a consequence of) Box 68760. physician pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 sl was an autopsy performed?
Yes 214 No 1□ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Alatural
2 Accident Injury 1 ☐ Yes 2 ☐ No s after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide ō within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of deam (Item 23a) (Type, Print) 05+1VA . D., VA maryland Health Core System, Perry Point, MO 21902

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 14

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			For State Ragistrar	State of Maryla		artmer ertificat				giene, Reg. No. 200	7 10077
			1. Decedent's Name (First, Middle, La	ist)					2. Date of De Month	ath Day Yea	3. Time of Death
	Physici: /Medic		JOSEPH	ANTHONY MA	RTINEZ				MARCH	*	4.4
	Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City	Town, or	Location of Deat	h	4c. County of De	
			LARKIN CHASE				BOWII		1	PRINCE C	
	Funeral			1XIM 2□E	rs. last birthday O.C. Yrs.	Months		If Under 24 Hrs Hours Min.	(Month, Da		irthplace (State or Foreign Country)
	Director		578-38-9195 Usuaf Residence of Decedent		86 Yrs.				JULY 2	0,1920   CA	LIFORNIA
	land ow		10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
	Mary -1 eh	ξ	MD. PRINCE	GEORGES		Τ.	ANHAN	1			17∏Yes 2 No
	r 28a	Director	10e. Street and Number	OHORODD			p Code			10g. Citizen of What	Country?
	3a o	D	9885 GREENBI	ELT RD. #100			207	706		U.S.A	
	deat ms 2	Funeral I	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	. Was Dece	dent of Hi		Specify Yes or No	14. Race - Ar Bfack, Wi	nerican fndian,
ထ္	after or Ite	F	1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		1 ☐ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "retural", or Items 23e or 28e-f ehow the Medical Examinar must be notified at	d by	3	Year or Dates: WW						, M	HITE
ν.	72 h natu	Completed	15. Decedent's 8 (Specify only highest gi		(Giv	edent's Usu e kind of wi DO NOT i	ork done d	luring most of wo	rking	16b. Kind of Busines	ss/Industry
72	within	m m	Efementary/Secondary (0-12)	Colfege (1-4or 5+)		ETAIL				FURNITURE	STODE
	filed Hygie other		17. Father's Name (First, Middle, Las		I. K.	LIAIL	SALI		me (First, Middle	, Maiden Sumame)	STORE
au	d be	) Be	UNK.	MARTINEZ					UNK.	COR	DELL
Maryland	should ind Men marka umatic	ဥ	19a. Informant's Name/Relationship		19b. Mai	ling Addres	s (Street a	and Number or R		er, City or Town, State	
	and 2 selth ar n 27 le		SALLY PROCTOR	/FRIEND	9505	WORR	ELL A	AVE., LA	NHAM, MD	20706	
altimore,	~ # E E		20a. Method of Disposition	20	b. Place of Disp	position (Na	me of	e)	Date	20c. Location - City	or Town, State
Ë	permit. Pages of Department of Informat: If Ite eny injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		CHAMBER	•	-		6-2007	RIVERDAL	E, MD.
alti	partm ports oorts / inju		21. Signature of Funeral Service Lige		-				HOME S. C	REMATORIUM	
m	90 E 8		W.W. Cho	merisar M	00091	5801	CLEVI	ELAND AV	E., RIVE	RDALE, MD.	20737
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)						c or respiratory a		Approximate Interval Between Onset and Death
Н	Examiner			Adv	sequence on:	DA	osl	ale a	ances		3 months
		Jer	Sequentially list conditions. if any, leading to immediate cause. Enter Underlying	b. Due to (or as a con	sequence oi):	1/					
	sate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c							
ő,	e exe	Ä	resulting in death) Last	Due to (or as a con	sequence of):						
8760,	icate b physic s the b	dicai		d							
9 x	death certific e ettending p id for use as i	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy					23d. Date of	delivery
Вох	etter offor u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 □ l 4 □ Pregnant at time		☐Ectopic   ☐ Other (s				Month	Day Year
P.O.	that the de ed by the e deteched f	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
	2 B B	by Pi	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying	cause give	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Vital Records,	-= " T								1 🗆	Yes 2. IMO 3. □	Probably 4 Dunknown
ပ္သ	aw requas been 2 should	plet	1)						24a. Was	an 24b. Were	autopsy findings available to completion of cause of
ď		Completed							perfe 1 ☐ Yes	ormed? death	? es 2□ No
Ta	ysiclan: The is certificate h director, page	Bec	25. Was case referred to edical examiner?					26. Place of De	ath (Check only		
	Physiclan: r this certific ral director,	To E	1 ☐ Yes 2 D No		2 🗆 ER/Outpati	ent 3 🗆 🗆	OA Oth	er: 4 Thursing	Home 5 ☐ Res	idence 6 ☐ Other (S	pecify)
n of	ding Pl	ü	27. Mann Death 1 Patural 5 Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	'	28c. Injun Wor		28d. Describe	how injury occurred	
sio	Attending r death. ector: After by the fune	catl	2 ☐ Accident investigate	he -		М		Yes 2 □No			0
Division	or Attendelter death Director:	Certification;	3 Suicide 6 Could not 4 Homicide determine			street, facto	ry, office			(Street and Number or wn, State)	Hurai Houte Number,
_	To the Hospital or Attending Phwithin 24 hours efter death. To the Funeral Director: Atter th completely filled in by the funeral	edicai C		Physician: To the best of my aminer: On the basis of exar							
	To the H within 24 To the F complete	Medi	one)	and manner stated.			9c. Licens			29d. Date signed (Mo	
	S With		29b. Signature and title of certifier	111.	in	. ,   2	1			3/4/	2007
-	3+1		pear					1043		1/11/	
			30. Name and address of person wh	o completed cause of death H. Lin, MD	(Item 23a) (Type	e, Print) 72.05	B	Hamove	2 PKW	Greens	elt. Md 20170
	Sta	ato.	31. Date filed (Month, Day, Year).	32 Pegistrar's S		1 -		,,		, ,,	7774 20//0
	Regist		MAR 15	2007	A A	234					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene and Items 24a, 25, 29d per droep 265; 03/29/07/dhb

			State of Maryland / Department of Holdstate Amend Items 24a,25,29d per drg a 865493/2	ealth and M∘ <b>9∉97⁄dhb</b>	-	giene Reg. No.	200	7 10070
	1 M		1. Decedent's Name (First, Middle, Last)		2. Date of De	ath	<del>200</del>	3. Time of Death
	Physici /Medio		Nancy Gail Mason		Month 3 / 2 0 /	2 0 0		9:30 A <sup>M</sup>
1	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death		4c.	County of Dea	
<i>y.</i>			Kline Hospice House Mt. Ai	J			rederi	ick
	Funeral Director		216-54-8176 1 M 2 F 56 Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 6 / 4 / 1	v. Year)	9. Bir	thplace (State or Foreign ountry) MD
	land It		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location					10d. Inside City Limits
	Mary -f sho	to	MD Frederick Frederick					1 ☐ Yes 2 🕅 No
	r 28a	Director	10e. Street and Number 10f. Zip Code			10g. Citiz	zen of What C	ountry?
	th wit 23a o ist be		5419 Jefferson Boulevard 21703			U	SA	
	ems er mu	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of His	spanic Origin? (Spec	cify Yes or No		14. Race - Ame Black, Whi	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1  Never Married 2 Married	Specify:	iicari, etc.		Specify:	hite
S O	72 h 'natu dical	etec	15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done de	tion uring most of workin	a	16b. Kir	nd of Business	/Industry
7	vithin han ' e Me	Completed	(Specify only highest grade completed) (Give kind of work done diffe. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done diffe. DO NOT use retired)		1	MD	0	11: 0:-
N T	iled v Hygie I <b>her t</b> nt, th	S	12 Office Adm  17. Father's Name (First, Middle, Last)	1 n 1 S t a t o				elling Ctr.
and	2 should be filed and Mental Hygi Is marked other aumatic event, <u>I</u> I	o Be	Joseph F. Carroll				,	
$\overline{\leq}$	should be fand Mental   s marked or umatic eve	2	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street a	Kathryn nd Number or Bural		~		Zin Code)
	1 and 2 s Health ar em 27 is ither trau		Donald E. Mason Jr. Husb. 5419 Jeffers					
ē,	es 1 a of Heg	- "	20a. Method of Disposition 20b. Place of Disposition (Name of	i Da	ate		cation - City or	
timore,	Pages nent of l int: If ite		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Resthaven Cem.	í	/2007	Fre	deric	k. MD
Balti	permit. Pag Department Important: I any Injury o		21 Signature of Funeral Service Licensee 22. Name and Address					P.A. F.H.
	a o	- 1	M01176   106 East				erick	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shoot, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.		respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	114 6	_			-
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	s Cell (	azai	10m	5	month.
	ecute and -trans	Examiner	Cause (Disease or Injury that Initiated events resulting in death) Last   C					
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9		edical	- U.			-		
O. Box	the death certifi / the attending ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐			2	3d. Date of de Month	livery Day Year
<b>a</b> .	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	n in Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
ords	w requires been sign should be	ted by	Meningeal Caranomatosis.		101	′es 2[	]No 3∏P	robably 4 Hriknown
Vital Records,	The la ate has page 2	Completed	<u> </u>				24b. Were at prior to death?	utopsy findings available completion of cause of 2 No
<b>X</b>	sictan; Th certificate rector, pag	Be	examiner?	26. Place of Death				Hacobe .
ō	Phys	<u>ا</u>	T   Tes 2   Te		e 5 ☐ Resid 3d. Describe h			city) Hospia house
O	nding th. : After s funer	igi	1, □Natural 5 □ Pending (Month, Day Year) Injury Work?	es 2□No	or Describe t	iow injury	occurred	
DIVISION	To the Hospital or Attending Physician: Within 24 hours after deals. To the Funeral Director: After this certification pletely filled in by the funeral director;	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28	Bf. Location (S City or Tow	Street and n, State)	d Number or Re	ural Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical ExamIner: On the basis of examination and/or investigation, in my opinand manner stated.	e, date and place, ar inion, death occurre	nd due to the d	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License D.4	number 164		29d. Date	signed (Mont	h, Day, Year) 03/20/07
			30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  A-Z-ttcAZ, 46B Thomas Johnson D	rive for	ederic	20	10 2	1702
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 9 2007  32. Registrar's Signature					
			Ages of Co.					

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2007

1. Decedent's Name (First, Middle, Last) Day **Physician** NARDI March 8 SANDRA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Cit Hopkins Hospital The Johns If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2XX Hours April 4,1953 Director 192-44-2268 Usual Residence of Decedent 10c. City, Town or Location 28a-f show Examiner must be notified Director Maryland Anne Arundel Annapolis 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number ö 2012 Quay Village Court Suite 101 21403 United States 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 72 hours after 1 ☐ Never Married 2 🗓 Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify: Specify. ģ 3 Widowed 4 Divorced "natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 73 th and Mental Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) Pavroll Supervisor State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Scioli Joseph Stewart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau 125 North Lee Street #207 Alexandria, VA 22314 Marita Nardi / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place George Washington 20c. Location - City or Town, State Plymouth Meeting Date 20a. Method of Disposition 1 X Eurial 2 Cremation 3 Removal from State 3/12/2007 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Pennsylvania Taylor Funeral Home, Inc. John M. 22. Name and Address of Facility

**Physician** /Medical **Examiner** 

> Examine Physician/Medical ģ Completed Be

The law requires that the death certificate be executed attending physician and for use as the buriat-tran for signed by the a cate has been signated bage 2 should b funeral director, I or Attending Fafter death. neral Director: / within 24 hours at To the Funeral C completely filled it To the Hospital

Box 68760,

P.0.

Division or Vital Records,

Medical State

Registrar

21. Signature of Funeral Ser 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 days disease or condition resulting in death) Aspiration Pheumonia Breast Caucer Metastatic 18 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Manner of Death

Natural

Accident 28b. Time of 28a. Date of Injury (Month, Day 28c 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

medica

and manner stated.

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Res-000

March

Time of Death

8:25 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

XX Yes 2 No

Pennsylvania

White

Black, White, etc.

address of person who completed cause of death (Item 23a) (Type, Print)

Street, Baltimore, Maryland , 600 North

MAR 1 3 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

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Вох
P.O.
Records,
Vital
o
Division

		_ For	• •	nd / Depa	artment of Health ar		-	10000
		1 = State Registrar		Ce	rtificate of Death	Re	g. No. UU/	10080
Physici		1. Decedent's Name (First, Middle, Last)  Arthur Lee	Noble. Sr.			2. Date of Death Month	Day Year	3. Time of Death
/Media		4a. Facility Name (If not institution, give			4b. City, Town, or Location of	March 1	5 . 2007 4c. County of Dea	7:50PM "
Examir	ıer	Manokin Manor Nur			Princess Anne			
Funeral		5. Social Security Number 6. Ser	x 7. Age (In yrs.	last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth	Somers 9. Bi	thplace (State or Foreign ountry)
Director		214-12-5544 Usual Residence of Decedent	M 2□F 85	Yrs.	Months Days Hours	Min. (Month, Day, 02/15/19	_	aryland
filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or items 23s or 28s-1 show ent, the Medical Examination notitied at		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation			10d. Inside City Limits
ith the Marylar or 28a-f show	ţō	MD Somerset	Dw	incess	Anna			1 ☐ Yes 2 💆 No
1 the	Director	10e. Street and Number		Theess	10f. Zip Code	10	g. Citizen of What C	ountry?
ous after death with the Maryla rai", or Items 23a or 28a-1 shov Examinar must be notified at	0	27876 Oriole Roa	ď		21853		USA	
ms 2	Funeral		12. Was Decedent Ever in U	.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No-	14. Race - Am	
after in the second	Ē	1 Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ No		32	uerto Rican, etc.)	Black, Wh	te, etc.
al. c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WWII		1 ☐ Yes 2 ⚠ No Specify:		Specify: Wh	nite
72 hours after death w "natural", or Items 23a alical Exentinal munit	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occupation kind of work done during most o	f working	6b. Kind of Business	
thin Me	gl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	, working		
od wi	Son	11	none	Build	ing Contractor		Home Imp	ovement
be file	Be (	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle, M	alden Sumame)	
should to	2	George A. Noble			Madel:	ine S. Noble	2	
es 1 and 2 should be filed within 72 ho of Health and Mental Hygiene if item 27 is marked other than "natur or other traumatic event, tra Medical		19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street and Number	or Rural Route Number,	City or Town, State,	Zip Code)
1 and 2 Health Ism 27 i		Arthur Lee Noble,	Jr./Son	2787	2 Oriole Road,	Princess Ar	nne, MD 21	.853
		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place)	Date 2	0c. Location - City o	Town, State
Pages nent of t		1 ⊠Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	temoval from State		rs U.M. Cem. 03	3/18/2007	riole. Ma	rvland
permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service License		22	2. Name and Address of Facility		722020, 110	L) Lund
	1	MANIN L CHINN	M00295		inman Funeral H 1673 Somerset A			MD 21052
William		23 . Part1. Enter the disease, or compli	ication that caused the deat	h. Do not ent	er the mode of dying, such as ca	rdiac or respiratory arres	st,	Approximate
Physician		shock, or heart failure. List only or immediate Cause (Final						Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a conseq	THEORY OF	N' 0			
Examiner			200 (0) 03 0 0011300	At	mentin			
3 - 31.	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):				
be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events						
be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or as a conseq	uence of):				
e be sicia e bur			4					
ficat phy as the	edic							
The law requires that the death certificate ate has been signed by the atlanding phys bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna				23d. Date of de	livery
death atte	cia	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)		Month	Day Year
at the de by the a	isk	9 Unknown	9□ Unknown					
res that igned b		Part II. Other significant conditions cor	ntnbuting to death but not res	ulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
uires I sigr	d by					1 ☐ Yes	: 2 ☐No 3 ☐ P	robably 4 Unknown
w requir been s	Completed					24a. Was an	24h Word 3	utopsy findings available
has has ge 2	E G					autopsy perform	prior to	completion of cause of
								2 □ No
Attanding Physician: r death. sctor: After this certifica by the funeral director, p	Be	25. Was case referred to medical examiner?	lospital:		Other	Death (Check only one		
Phys this al di	L L	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time of	1 3 DOA 4 Nursi	ng Home 5 Residen		ecify)
ding 1 After funer	Certification:	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work?	28d. Describe how	v injury occurred	
death death tor: the	Icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OD - Disea of lains At h		M 1 Yes 2 No			-10
or A after Direction by	i.	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y) y)	eet, factory, office	City or Town,	eet and Number or R State)	urai Houte Number,
urs a	1 1	00- 0-44	I The Table 1					
Hospitel 24 hours & Funeral tely filled	edica	Check only 2 Medical Examile	her: On the basis of examina	wiedge, deat ition and/or in	h occurred at the time, date and properties and properties are the control of the	place, and due to the call occurred at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
To the Hospitel or Attendi within 24 hours after death. To the Funers! Director: A completely filled in by the fu	Med	one)  29b. Signature and title of certifier	and manner stated.		29c. License number		d. Date signed (Mon	
F × 5 8	-							_
		Nahr			7 470 9	7	3/16/07	7
	1	30. Name and address of person who co	empleted cause of death (Item	n 23a) (Type,	Print)	W. San	G. 1695 . N	1278932
		Oll Marie		MO	2. WELLER HO	CIT	MO	-13 -4
		Od Data Blad / Manch Da Ward	20 0 - 41 1 21					
Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 9 2	32. Registrar's Signa	iture #	down to			

laurice Thomas		Well 1- For State Registrar	St	ate of Mary		partment o <i>ertificate o</i>			d Ment	tal Hy	_	Reg. No.	40		1000
Physicia Jedical Examin	n/	1. Decedent's Name		le,Last) AS POWELI	,						2. Date of De Month <b>March 1</b>	eath	Year		3 Time of Death 0137 hrs
		4a. Facility Name (if 6925 Central		on, give street and r	number)			, Town, or pitol Heig	Location o	f Death			c. County of Prince Ge		's
Funeral	7	5. Social Security Nu		6. Sex	7. Age (In yr	s. last birthday)		nder 1 Yea		r 24Hrs.	8. Date of E		/DD/YYYY)	9. Birth	place (State or
Director		218-19-80	30	1 <b>X</b> M 2_F		19 Yrs	Mor	nths Days	s Hours	Min	03-00	5-198	38	Foreigr Cou	ntry) <b>DC</b>
y.	F	Usual Residence of			140- 0	ih. Tama ad I									40d Incide City Limits
iow an		MD	Ob. County	CE GEORGE		ity, Town or Loca		L HEI	Сптс						10d. Inside City Limits  1 Yes 2 X No
Aaryland 28a-f show any 1 at once.	Director	10e. Street and Num		CE GEORGE	, 5	CAI		Zip Code	GHID			10g. Citi	izen of Wha	t Coun	
h the Ma 3a or 2		186 DAIML	FR DR	TVF				207	43				US	ΔS	
h with ms 23.	era	11. Marital Status		12. Was De	ecedent Ever in Forces?			dent of His			ecify Yes or N	lo-		Americ	an Indian, Black,
or deat	Funeral	1 X Never Married		arried Armed  1 Yes  Yorced If Yes, Give Yes	2 <b>X</b> No					r deno i	tioan, cto.				1 CTT
urs afte	≥	3 Widowed  15. Decedent's Edu		or Dates:		) 16a. Deceder		2 X No		ind of w	ork done	16b.	Specify: Kind of Busi		ACK dustry
72 hou n "nat	e e	Elementary/Secon			(1-4 or 5+)	during m			. DO NOT						
5-0036 led within 72 hours Hygiens of other than "natur the Medical Exam	Completed			1		STUD	ENT				-		ADE SO	CHOC	)L
21215-0036 Juld be filed within 7 Mental Hygiene marked other than event, the Medica	- 1	17. Father's Name (F		, Last)					18. Mother's		(First, Middle				
		19a. Informant's Nan		hip (Type, Print )		19b. Mailin	g Addre	ess (Stree	et and Num		ural Route N			State,	Zip Code)
MD d 2 shc lth and n 27 is		VERMELLE		L/MOTHER						, CA	PITOL				
ore, ME ss I and 2 s of Health an If item 27 her traums		20a. Method of Dispo	_	n 3 Removal		b. Place of Dispos crematory or of			metery,		Date	20c.	Location - C	City or 1	own, State
Baltimore, permit Pages I ar Department of He Important: If the injury or other it	ļ	4 Donation 5				RESURRE				3/2	1/2007	7 C	LINTON	, N	<u> </u>
Baltimore, MC permit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traums.		21 Signature of Fun	eral service	Licensee	200	, 22.1	vame ar								MD, INC. MD 20746
Physician		23a. Part I. Enter the failure. List only	disease, or	complications that	caused the de	ath. Do not enter t	he mod	e of dying,	such as ca	ardiac or	respiratory a	rrest, sho	ock, or hear	t t	Approximate Interval Between Onset and
/Medical Examiner	f	Immediate Cause (F	inal disease	a. Gunshot V		to Head and	Arm								Death
		or condition resulting		Due to (or as	a consequenc	e of):									
	ē	Sequentially list con- if any, leading to imm cause. Enter Under	nediate		a consequenc	e of):									
	티	(Disease or injury the events resulting in d	at initiated	C	a consequenc	e of):	-								_
				d											
O, e be exe /sician bunial -	edical	UNPENDED		AMENDED											
Box 6876( ne death certificate the attending physhed for use as the b	Σ	IF FEMALE: 23b. Was decedent p past 12 months?			, outcome of probinth		etal dea	th 3	Ectopic	pregnan	ncy	23	<ul> <li>d. Date of demonstrates</li> <li>Month</li> </ul>	elivery D:	ay Year
ox 6 ath cer	Sicia	1 Yes 2 No	_	(mayum 1 ==	gnant at time of	death 5 0	ther (S)	pecify)				Ç.			
s, P.O. Baires that the de	Physici	Part II. Other signifi		9 011K		ot resulting in the	underlyi	ing cause g	given in Par	rt I.	23e. Did	tobacco	use contrib	ute to t	ne cause of death?
P.O.	흵										1 🗌 Y	es 2	<b>/</b> No 3 □	Proba	ably 4 Unknown
cords, law require has been a 2 should	Completed										24a. Wa auto	s an opsy			opsy findings available ompletion of cause of
Recc	틹										per 1 🗸 Yes	formed?		ath? ✓ Yes	2 No
Vital Recysician: The last certificate la director, page	Be	25. Was case referre	ed to medica	Hospital:					of Death (			_			
f Viri	잂	1 ✓ Yes 2 27. Manner of Death		' -	Inpatient 2 e of Injury	ER/Outpatien 28b. Time of		DOA Iniu	Other <sub>4</sub>		Home 5 28d. Describ	_	ence 6		Scene
ion of tending Ph eath. oor: After the funeral	cation:	1 Natural	5 Pene	Mar 11	th, Day Year) , 2007	0128 hrs	ii ijui y		Yes 2	<	Subject wa				
Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si pety filled in by the funeral director, page 2 should be	ficat	2 Accident 3 Suicide		stigation 28e. Pla	ace of Injury - A	t home, farm, stre	et, facto	ory, office b	ouilding, etc	c. 1			and Number	or Rur	al Route Number, City
Divisal or At ours after deral Direct filled in by	Certifi	4  Homicide			Docal St	reet				6	or Town, 925 Centra	I Avenu	ie, Capitol	Heigh	ts, MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	edical	29a. Certifier (Check only one)	Certifying P	hysician: To the boominer:On the basis	est of my know	ledge, death occu	rred at t	the time, da	ate and pla	ce, and o	due to the ca	use(s) ar	nd manner a	s state	d. cause(s)
S in Si	Medi	29b. Signature and t		and manner	stated.			29c. Licens							th, Day, Year)
	-			1 .11	14			O.C.I					rch 11, 2		
0 0	}	30. Name and addre													
KU		Jack Titus M		outy Chief Med			nn Str	eet, Bal	timore, <b>N</b>	MD 212	201				
Sta Registr	te	31. Date filed (Month	R 2007	7A1 32. F	Registrar's Sigr	oper de									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30 M 100 ⁴/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** wite at NOVENTEST RANDALIJTOWN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 230-22-5886 1 №M 2 ☐ F Director irginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Od. Inside City Limits r 28a-f show notified at 1 Mes 2 No irginia Petersburg Funeral Director 10e. Street and Number 10g. Citizen of What Country? th and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 23803 United Hanover Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: i 948-1974 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Military Soldier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd., Reisterstown 101 Walgrove Health em 27 George 20a. Method of Disposition Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State Dinwiddie, Va. March 10,2007 Dinwiddie Memoria 4 Donation 5 Other (Specify) 22. Name and Address of Facility j. M. Wilkerson Funera Establishment 21. Signature of Funeral Service Licensee 102 South Ave, Petersburg, Va. 23803 300 MO1261 23a. P.111. Ever the disease, or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was a... autopsy performed? Yes 2 PNo 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: Medical Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) gistrar's Signature State MAR 2 6 2007 Registrar

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 2 To the I

Medical

31. Date filed (Month, Day, Year) MAR 1 4 2007 State Registrar

29a, Certifier

29b. Signature an



Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nedical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time, date and place.

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

			_			partment of I			giene	
			1 - State Registrar		-	ertificate of		-	Rag. No. 007	10084
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De. Month	ath Day Year	3. Time of Death
	/Medio	al	William Jerome						13, 2007	7:00 p <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give Holy Cross Nursin				or Location of Death onsville	1	4c. County of Dea	
	Funeral	**	5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Montgom	thplace (State or Foreign
	Director		377-34-0076	IXM 2□F	4 Yrs	Months Days	Hours Min.	(Month, Da Oct. 23	3, 1912 Was	hington, DC
	and		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl f eho	Į.	Maryland Howard			mbia				1 <b>X</b> Yes 2 No
	n the	Director	10e. Street and Number		- 0010	10f. Zip Code			10g. Citizen of What C	ountry?
	hours after death with the Maryland tural', or Iteme 23a or 28e-f ehow al Examinar must be notified at		9750 Polished Ston	ie			21046		USA	
	teme	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 1	<ol> <li>Was Decedent of If Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Ame Black, Whi	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates:	°WWII	1 ☐ Yes 2 🔯 No	Specify:		Specify:	White
21215-0036	d within 72 hours after death with the Marylan jene. Ir than "natural", or Iteme 23a or 28e-f ehow The Medical Examinat must be notified at	ted	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occu	pation		16b. Kind of Business	/Industry
215	within 7 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	life	ive kind of work done e. DO NOT use retire	during most of world)	-	GPO/	
2	il Hygien other th		12		Pri	nter		-	Wall Stree	t Journal
anc	o d a o	Be	17. Father's Name (First, Middle, Last) William S. Rhodes						Maiden Sumame)	
Maryland	should nd Me nmark umatik	٦	19a. Informant's Name/Relationship (7		19b. M	ailing Address (Street	1	S. Wil	er, City or Town, State,	Zip Code)
	nd 2 lith a 27 le r tra		Ursula S. Rhodes	- Wife	(1)	_			, MD 21046	
Baltimore,	ges 1 a it of Hea if item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Pamoval from State	20b. Place of Discemetery, of	sposition (Name of crematory or other pla	ice)	Date	20c. Location - City or	Town, State
Ĕ	Tit. Pag Sertment Sortant: I injury o		4 □ Donation 5 □ Other (Specify	)	Metropolit	an Cremato		0/2007	Alexandria	, VA
Bali	permit. Pages Depertment of th Important: If its eny injury or of		21. Signature of Funeral Service Licen	590	1000	22. Name and Addre	•		4739 Balti	
	201		23a Part1. Enter the disease, or comm	finations that caused	the death. Do not	asch's Fu	neral Hom	e, P.A.	<u>Hyattsvill</u>	e, MD 20781
7	Discolation		shock, or heart failure. List only of immediate Cause (Final	one cause on each lin	Э.					Interval Between
	Physician /Medical		disease or condition resulting in death)	a. Coro	consequence of):	yryery h	sisease			Many yrs
*	Examiner		Sequentially list conditions,	Diabe	tes, Hy	Artery Dertensi	on Hyp	erlipia	dem; a	Many yrs.
	Sit 9d	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of).					
_	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
760,	ate be executed hysician and he burial-transit	calE	(	d	3.7					
68	tificate ig phy as the			U						
Вох	th cert endin r use	an/M	23b. was decedent pregnant	23c. If yes, outcome o		3 □Ectopic pregnanc	v		23d. Date of de	
Э. Е	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐Unknown		5 Other (specify)			Month	Day Year
P.0.	that th	Phy	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the	a underlying cause or	ven in Part I	23e. Did to	obacco use contribute to	the cause of death?
Division of Vital Records,	w requires that the death certifica been signed by the attending ph should be detached for use as th	Completed by Physiclan/Medl	Urinary Refen	fron Ve	-+190	Hypothy	roidisa	101		robably 4 Unknown
CO	w req	lete	Esophageal Re	Hux -	Theamle	for vtos	15	24a. Was	an 24b. Were a	utopsy findings available
Be	hysicien: The law his certificate has t I director, page 2 s	шо				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		autop perfo	ormed? prior to death?	completion of cause of
ital	ien: artifica ctor. p	BeC	25. Was case referred to medical examiner?				26. Place of Dear			20140
> >	Physic this ce at dire	မ	1 ☐ Yes 2 ☑ No		t 2 ER/Outpa	IIBIIL 3L DOA			dence 6 Other (Spe	city)
no	Jing F After funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	y Wo	ry at rk? Yes 2 □ No	28d. Describe h	now injury occurred	
isi	Attendent death ctor:	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm.	street, factory, office	1162 5 140	28f. Location (S	Street and Number or R	ural Route Number.
Š	et or safter	Certification;	4  Homicide determined	building, etc.	(Specify)	,,	9.	City or Tou		,
	To the Hospitet or Attending Physicien: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier 1 Certifying Phy	ysician: To the best of	my knowledge, de	eath occurred at the tr	me, date and place,	and due to the	cause(s) and manner as date and place, and due	s stated,
	the hin 24 the F	Medical	one)	and manner stat	ed.					
	T wit		29b. Signature and little of certifier	The man	71)	29c. Licens	2 / m ~ 4	,	29d. Date signed (Mont	n, Day, Year)
2 6	10)111		30. Name and address of person who o	completed cause of de	ath (Item 23a) (Tur	ne Print) 7 Cre	31001	110000	31737	#420
76	1149		30. Name and address of person who control of the state o	ceuritz,	MD	Gre	en belt	MD	20770	# 7 >0
	Sta			32. Registra	's Signature	7.7			·	
	Registr	ar	MAR 1 6 2007	December D	· Open					

7-01678 felvin Austin Re	1	St - For State	pe or Print ir ate of Maryla	ind / Depar		Health and				arte este	107		800
Physicia	n/	Registrar  1. Decedent's Name (First, Middl  N-1-	<sub>le,Last)</sub> vin Austin Re					2. Date of D	Day	Year		Time of De	
Medical Examir		4a. Facility Name (if not institution 4207 Pear Street			4	b. City, Town, or Capitol Heig		March 2	40	County of	Death	1022 111	
Funeral Director		5. Social Security Number 577–06–0401	6. Sex	7. Age (In yrs. las 29	t birthday) Yrs.	If Under 1 Year Months Days	+		Birth(MM/ 14, 19	оруууу) 977	9. Birthpl Foreign Countr	Lhck	or hingtor
Maryland 28a-f show any <u>d at once.</u>		Usual Residence of Decedent  10a. State 10b. County  D.C.		10c. City, T	own or Location	Wash	ington				1		City Limits 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 40 Burns Street	et, N.E.	160		10f. Zip Code	20019		10g. Citizen of What Country U.S.A.			?	
after death al", or iter	by Funeral	3 Widowed 4 Div	Armed Formation 1 Yes  Vorced If Yes, Give Yea or Dates:	2 X No	1	s Decedent of Hises, specify Cuban Yes 2 🕺 No	, Mexican, Puer specify:	to Rican, etc.)		14. Race - White, Specify:	etc. Bla	ck	ack,
5-0036 led within 72 hours lygiene. other than "natur:	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12th grade				t's Usual Occupation of working life.				Department Of Public			: Works
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene 127 is marked other than umatic event, the <u>Medica</u>	Be		n Lewis Austi	in			18.Mother's Nar	Kan	en De	nise Pe			
MD 21 Id 2 should alth and Me in 27 is ma	_[	19a. Informant's Name/Relations Karen Denise Reid			40 Bur	Address (Street		9					
Baltimore, MD 2121 permit Pages I and 2 should be fil Department of Health and Mental I Important: If tiern 27 is marked injury or other traumatic event,		20a. Method of Disposition  1 Surial 2 Cremation  4 Donation 5 Other S  21. Segnature of Funeral Service	pecify:	om State Cre	matory or oth nony Men	ition (Name of cer per place) prial Parl ame and Address	c March	12, 2007	7 La	ndover	, Mary		
		23a/Part I. Enter the disease, or	mberon	aused the death. [	43	39 Hunt P.	ace, N.E	. Washing	gtan, i	D.C.	20019	Approxima	te Interval
Physician /Medical Examiner	1	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. e a. <mark>Multiple G</mark> u	inshot Wound							-	Between C Dea	Onset and
	iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):									
cuted nd transit	I Examine	(Disease or injury that initiated events resulting in death) Last		consequence of):									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		UNPENDED  IF FEMALE: 23b. Was decedent pregnant in ti past 12 months?  1 Yes 2 No 9 Un	the 1 Live b	ant at time of deal	2 Fe	tal death 3 her (Specify)	Ectopic preg	gnancy	23	d Date of o	delivery Day		Year
s, P.O. Boires that the de risigned by the		Part II. Other significant condi		o death but not res	sulting in the u	ınderlying cause ç	given in Part I.			use contrib	-		death? Jnknown
(ecords, The law requir ate has been si	Completed by	-						pe	as an atopsy erformed?	pi de	Vere autoprior to comeath?		s available cause of
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	of Injury	ER/Outpatient	3 DOA njury 28c. Inju	ry at Work?	ck only one) sing Home 5 28d. Descri	be how inj	ence 6 v	_	cene	
Division ital or Attendi urs after death ral Director:	Medical Certification:	2 Accident Inve	estigation 28e. Plac	e of Injury - At hor			Yes 2 No	28f. Location	n (Street a				mber, City
To the Hospital within 24 hours completely filled	dical C	29a. Certifier 1 Certifying F	Physician: To the beaminer: On the basis	of examination an	e, death occur d/or investigat	red at the time, d	ate and place, and death occurre	and due to the ded at the time, d	ause(s) ar	nd manner ace, and d	as stated ue to the c	ause(s)	
<b>→</b>	Me	29b. Signature and little of certifi	ig.			29c. Licens				Date signerch 3, 20		, Day, Year	7)
ne l		30. Name and a res of pers Mary G/Ripple MD.	t, Baltimore,	MD 21201									

, M

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

			T = For State Registrar	State of Maryla		artment of Hertificate of D			iene 0 0	7 10	086
	- 16		1. Decedent's Name (First, Middle, Last)					2. Date of Death			e of Death
н	Physici /Medio		Virginia Gupton Ru	shton			ı	Month Iarch	15 20	07 2:00	o am M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of		
			1975 Sandy Point R	oad	1	Nanjemoy,	Maryland	1	Char1	es	
	Funeral		Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Vear	9. Birthplace (Sta Country)	te or Foreign
ı.	Director		243-16-5880	M 2∏F 90	Yrs.	Worth's Days	riodis IVIIII.	ugust 1	1916	North Ca	arolina
	p ,		Usual Residence of Decedent  10a. State 10b. County	100.6	city. Town or Lo					14044-14	00.11.00
	anyla ehov	-	Tod. State	100.0	ity, sown or Lo	cation					e City Limits
	88 -f	ct	Maryland Charles	Nar	njemoy						Yes 2 No
	with th	吉	10e. Street and Number			10f. Zip Code			g. Citizen of Wh	at Country?	
	ath v	by Funeral Director	1975 Sandy Point R			20662			JSA		
	er de	nue		12. Was Decedent Ever in the Armed Forces?		Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indiar White, etc.	٦,
36	rs aft	γ	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 24 No If Yes, Give Year or Dates:		I□Yes 2ŪXNo	Specify:		Specify:	White	
8	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or items 23a or 28s-f ehow int, the Macifical Examiner must be mullian and	ed	15. Decedent's Edu		16a Dece	dent's Usual Occupat	tion		6b. Kind of Busin	nace/Industry	
5	n n	Completed	(Specify only highest grade	completed)	(Give	kind of work done du DO NOT use retired)	ırina most of work	ing	OU. KING OF DOOR	nosa moostry	
212	y with	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Fisca	l Account	ing Direc	tor [	epartme	nt of Na	avy
ğ	othe	0	17. Father's Name (First, Middle, Last)				18. Mother's Name				2
Baltimore, Maryland 21215-0036	lenta ked ic ev	To B	Norman Lewis Gupto	on			Lilly Ho	yle Gupt	on		
a <sub>Z</sub>	shou a ma	Ξ,	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailir	g Address (Street ar	nd Number or Run	a <i>l R</i> oute Number,	City or Town, St.	ate, Zip Code)	
Σ	is 1 and 2 of Health ai item 27 is other treu		Lorraine Collins No	orthern/Daugh	nter 840	08 Granite	Springs	Rd. Spo	tsylvan	ia, VA.	22553
ē,	item othe		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	March	Pate 19. 2	Oc. Location - Ci	ty or Town, State	9
Ĕ	Page lent c nt: if ry or	П	1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		cham Cer		, I		ronside	s. Marvl	land
=	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturet", or items 23a or 28a-1 show eny injury or other treumatic event, the Marical Examinating the nutitiest at ODGs.		21. Signature Juneral Service License			. Name and Address	of FacilityAreh				
m	Depa Depa Impo eny is		Variet T Calant	MO1458		.O. Box 56					
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the dea	ath. Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	st,	Approxi	
	Physician		Immediate Cause (Final	e cause on each line.	1.						Between nd Death
*	/Medical		disease or condition resulting in death)	Due to (or as a conse	aTic	Canc	Q 1		<del></del>		
	Examiner			·	4						
		ē	Sequentially list conditions, 1 any leading to immediate	Due to (or as a nonse	quence of)-						
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	an ar rial-t		resulting in death) Last	Due to (or as a conse	quence of):						
8760,	Attending Physician: The law requires that the death certificate be executed rideath.  Cadeath.  Cator: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial transit.	cal		1.							
	ng pt	Physician/Med	IF FEMALE:								
Box 6	leath certific attending p	an/	23b. Was decedent pregnant 23	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of		
Э.	a dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Other (specify)			Month	n Day	Year
Р. О	at the	Phy	9 🗆 Unknown								
	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause giver	n in Part I.		acco use contribe		
Hecords,	pluo s nee	ted						1 Te	s 212No 3	Probably 4	□Unknown
ပ္ပံ	has by	ed (						24a. Was an autopsy	24b. We	re autopsy findir or to completion	ngs available
	The ate h page	Completed						perform	ed?// dea	ith? Yes 2□ No	
<u> </u>	ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of Deatl				
$\leq$	Attending Physician: The isr death. •ctor: After this certificate he by the funeral director, page	ပ္	1 ☐ Yes 2 No		☐ ER/Outpatien	t 3□ DOA Cther	4 Nursing Ho	me 5 Resider	nce 6 Other	(Specify)	
Ē	ing P	ü.	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at	28d. Describe how			
SIO	tend leath tor: A	catl	2 Accident investigation 3 Suicide 6 Could not be				es 2 No				
Division of Vital	or At lifter of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At to building, etc. (Special	home, farm, stre ify)	eet, factory, office		28f. Location (Str. City or Town,		or Rural Route N	lumber,
	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		One Consider	later T							
	To the Hospital within 24 hours a To the Funerel Completely filled	edical	29a. Certifier (Check only one)  Certifying Physical Examination	sicien: To the best of my kn ner: On the basis of examin	nowledge, death nation and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occurr	and due to the car ed at the time, da	use(s) and mann te and place, and	er as stated. I due to the caus	se(s)
	thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. License			d. Date signed (i		
1	8 7 % 7			Hanne				25	2/10/	, Day, 18d	',
,			Hames 1	faring		000 50	1717		9/17/0	1	
	181		30. Name and address of person who co	7	m 23a) (Type,	Plata	mp	2064			
000	シリ b Sta	to.	31. Date filed (Month, Day, Year)	32. Prigistrar's Sign	nature	11914	(1)	~ 6			
	Registr		MAR 1 6 20		1 A	rest !					

			1 - For State Registrar	State of M	arylar		artmen rtificat			and M		jiene	007	Proposition of the Park	087
			1. Decedent's Name (First, Middle, Last	)							2. Date of Dea				e of Death
м	Physici /Medio		Mary I	ougherty	Reev	es					Month March	Day 11,	Year 2007		320 M
	Examir		4a. Facility Name (If not institution, give	street and number,			4b. City,	Town, or	Location of	f Death		4c. (	County of Dea	ath	
			Harford Men	orial Ho	spita	1		Hav	re de	Gra	ce		Ha	arford	
	Funeral		5. Social Security Number 6. Se	,	je (In yrs.	last birthday,	If Under		If Under 2	24 Hrs.	8. Date of Birth (Month, Day	) Vand	9. Bi	rthplace (Sta	te or Foreign
	Director		196-18-4174	M 2 KgF	82	Yrs.	Months	Days	Hours	Min.	June 13	1 9 1 9	24 1	ennsy	lvania
	P .		Usual Residence of Decedent												
	rylar	_	10a. State 10b. County		10c. Cit	y, Town or L	ocation								e City Limits
	Ma Ma	cto	Maryland Ceci	1				Peri	ryvil	le				182	/es 2□No
	or 28	)Ire	10e. Street and Number				10f. Zip	Code				0g. Citiz	en of What C	ountry?	
	23a	Funeral Director	1454 Clayton Stre	et				2.	1903				U.S	.A.	
	eep .	ine	11. Marital Status	12. Was Decedent Armed Forces	Ever in U	.S. 13.	Was Deced	dent of His	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Wh		١,
စ္က	or It	Ŧ	1 ☐ Never Married 2 ☑ Married	1 ☑Yes 2 ☐	No		1 🗆 Yes			,	,		Canaitu		
ğ	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	1944	-46							Specify.	White	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f show the Madical Examiner mal be multing a	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		(Give	dent's Usua kind of wo	rk done d	urina most	of workin	g	16b. Kin	d of Busines:	s/Industry	
12	Aithir Bne.	Ę	Elementary/Secondary (0-12) Twelve Years	College (1-4or	5+)	ilfe.	DO NOT US	,				_			
N	Hygie Hygie Ther I		17. Father's Name (First, Middle, Last)				HOI	memak		da Nama	(First, Middle,		ersona	I Resi	.dence
Maryland	d of o	Be		Danahant					TO. MICHTER				,		
Ë	d Me nark natio	J.	Patrick D.  19a. Informant's Name/Relationship (Ts		У	105 14 33		(0)			Sertrud				
Ma	12 si h an 7 le r		Calvin C. Reeves	(Husband	١						Route Number	-			000
	1 and Healther ther		20a. Method of Disposition	(nusband							ate		ation - City o		.903
ွဲ	or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State		lace of Dispo									
altimore,	rtmer rtant njury		4 Donation 5 Other (Specify)		St.	. Mark				03/16	5/07	Perr	yville	, Mary	land
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Emportant: If Item 27 is marked other then "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Licens		~ 50.		2. Name an ee A.				Son Fund	eral	Home.	P.A.	
		0 0	23a. Part 1. Enter the disease, or compl	TUCE	OOM	P	errvv	ille.	Mars	vland	2190	3-07	56		
			snock, or near failure. List only of	ne cause on each I	ne.							est,		Approxi Interval Onset a	mate Between nd Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. met	asta	tic p	ancr	eati	c (a	ince				3 mon	.ths
	Examiner			Due to (or as	a conseq	uence of):									
	34	-	Sequentially list conditions. if any, leading to immediate	Due to (or as	a consec	uence of):									
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (0) 02	4 4011004	uonoo on.									
	al-tra	xar	that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial transit														
687	ficate phy: s the	Physician/Medical		J											
Box	certii nding Ise a	N.	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregna	incy						2.	3d. Date of de	linear (	
m	atte	clar	in the past 12 months?	1□Live birth 4□Pregnant a			☐Ectopic pr ☐ Other (sp					-	Month	Day	Year
P. O.	that the death certific ed by the attending p detached for use as	ys	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown			(-,-								
<u>.                                    </u>	res that signed b		Part II. Other significant conditions con	ntributing to death b	ut not res	ulting in the u	nderlying c	ause givei	n in Part I.		23e. Did to	acco us	e contribute t	o the cause	of death?
g	puires n sign	d by	polymyalgia r	heunatica							1 🗆 Y	s 28	<b>(</b> No 3□P	robably 4	□Unknown
8	w require been si should b	lete	Altheimers De	mantic							24a. Was a		24b. Were a	utopey findir	ige available
æ	Physician: The lav this certificete has al director, page 2	Completed	(1101714)								autops	y	prior to death?	completion	of cause of
Ø			25. Was case referred to medical									2⊠ No	1 🗌 Ye		
>	sicia cert irect	o Be	examiner?	lospital: Inpati		CD/0-1		Othe	_		(Check only on				
ō	Phy arthis	. To	27. Manner of Death	28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o		<u></u>	4 🗆 Nui:		e 5 Reside			ecity)	
<u></u>	ding f th. : After s funer	it o	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	М	8c. Injury Work' 1 □ Y	? es 2 □ N			. ,			
Division of Vital Records,	Attending Physician: In death.  Cotor: After this certifice by the funeral director.	flea	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	ury - At ho	me, farm, str	eet, factory	, office		21	8f. Location (Si	reet and	Number or A	ural Route N	lumber.
ă	al or afte Dir d in t	Certification:	4  Homicide determined	building, et	c. (Specif	1)					City or Towi	, State)			
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner st	t examına	wledge, deat tion and/or in	h occurred vestigation,	at the time in my opi	e, date and inion, death	place, ar	nd due to the co	ause(s) a ate and p	ind manner a place, and du	s stated. e to the caus	e(S)
	To the To the Comp	Me	29b. Signature and title of certifier	pm .	ND.			License			2		signed (Mon	th, Day, Yea	r)
			pendent -	mule, "	- 9"		U	004	8050			3/	3/07		
J	5+IVA		30. Name and address of person who co Prashant Shukla	impleted cause of c	leath (Item	23а) (Туре,	Print)	no 1	ΔĹ1	4	10715	0 1			
			trashant Shukla, 31. Date filed (Month, Day, Year)	MU 15 5	. ravk	? Stree	+ + 7	W 1	19016	en IV	10 210	01			
	Sta Registr	-	MAR 1 4 2007	Server .	di si Signa	porte	,								

within 2 To the 1

State

Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a)



29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 13, 2007

Registrar

viima Dariene	KICH	1- For State Certificate Registrar	nt of Health and Mental H e of Death	ygiene Reg. No. 200	07 10089
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Wilma Darlene Richards		2. Date of Death  Month Day Year  March 23, 2007	3. Time of Death 0625 hrs
Ä		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	Peath
Funeral		293 East Main Street Apt 8  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Frostburg  If Under 1 Year If Under 24Hrs	Allegany  8. Date of Birth (MM/DD/YYYY)	). Birthplace (State or
Director		212-54-8243 <sub>1 M</sub> 2 58	Yrs. Months Days Hours Min	<b>→</b> ` 1-	oreign Country)Mary1and
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
À.	Ļ	Maryland Allegany Frostb			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g Citizen of What	Country?
th the Maryland 23a or 28a-f she notified at once		293 East Main Street Apt. 8	21532	U.S.A	
eath wi	Funeral	1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.) 14. Race - A White, e	merican Indian, Black, tc.
after d al", or	by Fu	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify:	white
hours natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	cedent's Usual Occupation (Give kind of ving most of working life. DO NOT use reti	vork done 16b. Kind of Businered)	ess/Industry
C1 . =	ompleted		echnician	silk so	creen
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Cor	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
2121 uld be: Mental marke	To Be	Edward Cape 1  19a. Informant's Name/Relationship (Type, Print )  19b. N	Ruth Mailing Address (Street and Number or F	Nelson Rural Route Number, City or Town, S	State, Zip Code)
MD d 2 sho th and n 27 is	-	Randall L. Richards son 29	3 E. Main St. A	pt 8 Frostburg	g, MD 21532
Baltimore, MD 21215-0 permit Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If iten 27 is marked oth injury or other traumatic event, the.		1 Burial 2 VCremation 3 Removal from State crematory	or other place)	/28/0/1	
timent trant: trant:		4 Donation 5 Other Specify: Cumber	land Crematory  22. Name and Address of Facility		land,Marylan
Bal permi Depar Impo injuri			Durst Funeral H	57 Frost ome Frostburg	Ave. g,MD 21532
Physician		23. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	nter the mode of dying, such as cardiac o		Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive atherosc.  Due to (or as a consequence of):	lerotic cardiovascular o	lisease	Death
- All San Control of the Control of		Sequentially list conditions,  b			
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
الله و حرابه	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	···		
recul	ical	d.  **UNPENDED #MENUFERT 27 porMF 086	66 1/6/07 TT		
760, cate be ex physician he bunal	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
Box 6876 he death certificat the attending phi hed for use as the	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregna  Other (Specify)	ncy Month	Day Year
Box e death c the atten	hysic	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)		
ires that the d signed by the	by P	Part II. Other significant conditions contributing to death but not resulting in Chronic obstructive pulmonary disease	the underlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death?  Probably 4  Unknown
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for t	eted	on one obstructive pullionary disease		24a. Was an 24b. Wer	e autopsy findings available
of Vital Records, ng Physician: The law requir Wher this certificate has been s meral director, page 2 should i	Completed			performed? deal	r to completion of cause of th? Yes 2 No
Vital Rec hysician: The this certificate I director, page	Be Co	25. Was case referred to medical	26.Place of Death (Check		
n of Vital I ing Physician: After this certiff funeral director,	0	Tes 2 No	atient 3 DOA Other Nursine of Injury 28c. Injury at Work?	g Home 5 Residence 6 🗸 0	Other: Scene
	ion:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Tim	1 Yes 2 No	20d. Describe now injury decurred	
Division tal or Attendirs after death.	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	, street, factory, office building, etc.	28f. Location (Street and Number of Town, State)	or Rural Route Number, City
Divisi spital or Att tours after d neral Direct filled in by	Cert	4 Homicide determined (Specify)		or rown, state)	
Division  To the Hospital or Attendi within 24 hours after death To the Funeral Director: , completely filled in by the fi	ledical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death one)  2 Medical Examiner: On the basis of examination and/or inve			
To T	Med	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
		and	O.C.M.E.	March 24, 20	07
0-		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 2120	1	
	tate		na Sueet, baltimole, IVID 2120		-
Regis		31. Date filed (Month, Day, Year)  AR 2 9 2007			

			State of Maryland / Department of F  Certificate of		_	iene	7 10090			
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth	Dev	3. Time of Death			
N. C.	/Medi	cal	HARRIET ROGERS SAVINGTON  4a Fecility Neme (If not institution, give street end number)	4h City Town or	MARCH 1	4c. County	07 21:35 PM			
1	Examir	ier	CHESTER RIVER MANOR	RTOWN	KEN					
	Funeral Director		5. Social Security Number 218-20-6612 6. Sex 1 Months 1 M 2 M F 98 Yrs. 1 Months Days	1.0 0.0 ((1.10) Months Days Hours Min						
	pu k		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
	Manyle	Ď	MD QUEEN ANNE'S MILLINGTON				1 ☐ Yes 21 No			
	uth with the Marylar 23e or 28e-f show	Funeral Director	10e. Street end Number 210 PETERS CORNER ROAD 10f. Zip Code 2165	51	10	g. Citizen of V USA	Vhat Country?			
020	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ha Madical Examiner must be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes, 2 No Yes, Give Yes, Give Year or Detes:  13. Was Decedent of H If Yes, specify Cuba I Yes, Give Year or Detes:	lispanic Origin? ( an, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)		e - American Indian, sk, White, etc. .: WHITE			
7200-912	72 ho	eted	15. Decedent's Education (Specify only highest grede completed)  16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retires	ation during most of we	orking 1	6b. Kind of Bu	usiness/Industry			
7	within ene.	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired HOMEMAKER	1)		OWN	HOME			
land	ld be filed ental Hygi ked other ic event, ti	o Be Co	17. Father's Name (First, Middle, Last) THOMAS WESLEY HOLDEN		ame (First, Middle, M ANN WALRA		99)			
iary	2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street							
6, ≥	1 and Health em 27 i	-	EVELYN GLANDING/DAUGHTER 210 PETERS C	ORNER RO			MD 21651 City or Town, State			
TIMOL	t. Pages tmant of I tant: if ite		1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  CRUMPTON CEMETER	RY	03/19/07	CRUMP	TON, MD			
Dall	Depar Impor any in	J	21. Signature of Funeral Service Licensee  22. Name and Addre FELLOWS, H 130 SPEER	SECTION OF SECTION SET IN SECTION OF SECTION	IN AND NEW HESTERTOWN	NAM FU MD 2	NERAL HOME, PA			
	Dhusisian		23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying mock, or heer failure. List only one cause on each line.	ig, such es cardia	ac or respiratory arre	st,	Approximate Interval Between Onset and Death			
)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1715			5 days			
	Examiner	_	resulting in death)  Due to (or as e consequence of):							
	uted d ansit	Examiner	b							
,	pata ba axacuted shysician and the bunal-transit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							
00/00	physic the bu	dicai	Cause (Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
D XO	certificata nding phys use as the	Me	d							
0	death e atten	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giv	en in Part I.	23b. Did tot	oacco use cor	ntribute to the cause of death?			
7.	d by th	Phy	ALZHEIMERS DEMENTIN		1 □ Ye	8 20 No	3 ☐ Probably 4 ☐ Unknown			
ords,	requires that tha reen signed by th hould be datache	d by			24a. Wes an	autopsy	24b. Were autopsy findings			
5	law req as beer s 2 shou	piete	CONGESTIVE HEART FAILURE		perform	ed?	available prior to completion of cause of death?			
	Physician: The law requires that tha death certificathis certificate has been signed by the attending plant director, page 2 should be datached for use as t	Completed			1 □ Ye	s 2 UNO	1 □ Yes 2 1 No			
N 150	iclan: certific rector,	Be	25. Was case referred to medical examiner?  Hospitel: Hospitel: Other Control of Control		eath (Check only one					
5	Physic this of the second dispersion of the se	2	27. Manner of Death 28a. Dete of Injury 28b. Time of 28c. Injury	4 DSUNUISING I	Home 5 ☐ Resider 28d. Describe how					
5	Attending Physician: or death. ector: After this certific by the funeral director.	atio	2 Accident investigation M 1	rk? Yes 2 □ No						
5	tal or Atters as all Directors of in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Str. City or Town,		er or Rural Route Number,			
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	29a. Certifier (Check only one)  20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To To To E	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Dey, Year)  3 / 15 / 2007								
-	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CHTS	TERTON	MW	0 21670			
10	Sta	re	31. Date filed (Month, Day, Yeer)  MAR 1 9 2007  Section 1 1 2007			•				
DHI	Registr 4H 16 Rev 6/95		MAR 1 9 2007 Been & Just							

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mary		ertificate of t		∕lental Hy	giene Reg. No.	07	10091
	Physic	an	1. Decedent's Name (First, Middle, La	st)				2. Date of D	eath Day	Year	3. Time of Death
-	*'/Medi		Patricia Mae					Marc	h 11 2	2007	1700 ™
	Exami	ner	4a. Facilify Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. Count	y of Death	
	_		Carroll Hospit  5. Social Security Number 6.5		a uro loct hirthdo		minster If Under 24 Hrs.	9 Date of Bi		arrol	
6	Funeral Director			John 2 F 7. Age (//	n yrs. last birthda Yrs.	Months Days		8. Date of Bi (Month, D	ay, Year)	9. Birthpla	ace (State or Foreign ry)
ū.			217-38-2151 Usual Residence of Decedent		65			Apr 1	7 1941		MD
	yland now		10a. State 10b. County	10	Oc. City, Town or	ocation				10	d. Inside City Limits
	a-fsl	Funeral Director	MD Carr	oll	Fin	ksburg					1 ∐Yes 2 💆 No
	or 28	Jire.	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	23a ust b	<u>ra</u>	2525 Baltimo	re Blvd	Lot 18		048		_	SA	
	er dez	nu	11. Marital Status	12. Was Decedent Eve Armed Forces?	rin U.S. 13	<ul> <li>Was Decedent of If If Yes, specify Cub</li> </ul>	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14. Ra	ce - America ck, White, e	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ KNo	Specify:		Specij	<sup>iy:</sup> Wh	nite
15-0	n 72 h "natu edical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of worked)	d <b>n</b> g	16b. Kind of B	usiness/Indi	ustry
12	withii iene. than the M	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	1110	Homem	_		Ow	n Hom	16
	filed Hygi other	S	17. Father's Name (First, Middle, Last	)		Homen	18. Mother's Nam	e (First, Middle			<u></u>
Maryland	12 should be filed v n and Mental Hygie 'Is marked other t raumatic event, th	To Be	Elmer Ile				unkne	own		,	
37	should I and Men s marker umatic	-	19a. Informant's Name/Relationship (	Type. Print)	19b. Ma	ling Address (Street	t and Number or Rui		ber, City or Town	, State, Zip i	Code)
	1 and 2 Health a em 27 Is		Howard Schaaf	/son	17	35 Joan	Ave Pari	kville	, MD 2	1234	
ľe,	of He		20a. Method of Disposition		20b. Place of Dis	oosition (Name of ematory or other pla	02/		7 <sup>20c.</sup> Location		vn, State
E	Pages Inent of Hant: If ite		1 ☐ Burial 2 ☆Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Speci</i> i		-		ion, In	•	Hamps		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service Lice	nsee	T	22. Name and Addre	ess of Facility uneral H	Iome ai	nd Char	ool	<u>гл</u> л
8	99 = 89	-	1			12 Wash	ington R	Road We	estmins	ter,	MD21157
E	Ę.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, Metast	tie 1	ung Ca	ncer				Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	J	100		i la		-
н	LXammer	Ļ	Sequentially list conditions,	b. Ihvoh	bus L	e-F-ANIU	in K Mill	mohar	1 very		
	ped list	je	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co		Para Di	10010				
	al-trai	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	onse tience of):	ary ar	1000			- 1	
68760,	ificate be executed g physician and as the burial-transit			a Atri	al th	rillati	NV				
.89		edical		1,500,000	- 1					- 5	
Вох	leath certifi attending I for use as	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐		□Ectopic pregnanc			23d. Da	ite of deliver	у
	deat ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tim 9□Unknown		☐ Other (specify) _			Mo	onth E	Day Year
P.0	The law requires that the death cert te has been signed by the attendin, tage 2 should be detached for use	Physician/M	9 ☐ Unknown					1			
	igned	by	Part II. Other significant conditions	Subseta			ven in Part I.				cause of death?
orc	w requir been si should t	ted	1900	1 Diascio	) I lew	0 1 - 03	-	וי	Yes 2 No	3∐ Proba	bly 4. Unknown
ec	e law has b	agr.		PIS				24a. Was	psy	Were autop	sy findings available pletion of cause of
F		Completed						perfe 1 Yes	ormed?	death?	P No
or Vital Records,	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:		0.1	26. Place of Deat	h (Check only	one)		
0	Phys r this ral dir	1	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outpati		4 LI Nursing Ho		idence 6 Oth	1 1 27	 
no	ding I. After fune	io	1 → Matural 5 ☐ Pending	(Month, Day Ye		Woi	rk? ]Yes 2 □ No	200. Describe	how injury occur	rea	
Division	deatl ctor: y the	licat	3 Suicide 6 Could not be		At home, farm, s		1163 2 110	28f. Location /	Street and Numb	per or Rural	Route Number
Ξ	al or / s after il Dire	Certification:	4 Homicide determined	building, etc. (S	Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			wn, State)	TOT OF FILIDA	riodio ridificoli,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or	nth occurred at the ti nvestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	cause(s) and m., date and place,	anner as sta and due to	ited. the cause(s)
-	To the Tro the Comp.	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, D	ay, Year)
	111		h 1 1sts.	ld Con		039	502 MV.	7	3/111	70	
	My		30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)				1 1	
	4		Syed S. F	to sain ho	447	E Mail	nst We	otherin	ster,	MU	VUJ I
	Sta		31. Date (ijed (Month, Day, Year) MAR 1 4	32. Registrar's		1					
	Registi		MAR 1 4	2007 Slow	v K,	Grande					
DHI	MH 17 Rev 1/2	U01									

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) **Physician** ERNICE /Medical Eacility Name (If not institution, give street and number) Examiner 5. Social Security Number **Funeral** 213-24-1490 Director Usual Residence of Decedent death with the Maryland 10a. State show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at MD **Funeral Director** 30739 11 Marital Status altimore, Maryland 21215-0036 þ

Completed

permit. Pages 1 and 2 should be fil.
Department of Health and Mental H,
Important: If Item 27 is marked oth,
any Injury or other traumatic more.

**Physician** 

/Medical

Examiner

physician and s the burial-trans

as

signed to

this

24 hours after death Funeral Director:

within 24

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Completed by

Be

Certification: To

10c City Town or Location Yrincess 10e. Street and Number Division ST. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 ☐ Widowed 4 ♣ Divorced

1□M 2**X**F

REGIONAL

15. Decedent's Education (Specify only highest grade completed)

6. Sex

tol K

EDICAL

College (1-4or 5+)

7. Age (In vrs. last birthday)

80

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify

(Give kind of work done during most of working life DO NOT use retired)

Carcinoma

21853

4b. City, Town, or Location of Death

ALISBURT

Days

If Under 1 Year | If Under 24 Hrs.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

SIEVENSON

Months

10f. Zin Code

16a Decedent's Usual Occupation

roduction

16b. Kind of Business/Industry Campbell Soup Ca

Y01X Kaymond 19a. Informant's Name/Relationship (Type. Print) Brenda Stansbury - Daughter

Elementary/Secondary (0-12)

17 Father's Name (First, Middle, Last

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1454 Shot Town RD

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Ò.

20b. Place of Disposition (Name of cemetery, crematory or other place) Mary's Comotern 3-16-2001 Trincess Anne MV
22. Name and Address of Facility Anthony E. Ward Funcial Home 30634 Hampden Are Braces Anne MI)

Date

23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of)

Gastriu

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

a I Inknown

2 ER/Outpatient

24a. Was an autopsy 2 No

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

Hospital: 1 Ninpatient 28a. Date of Injury (Month, Day Year)

and manner stated.

3□ DOA 28c. Injury at Work?

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined

28b. Time of 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

26. Place of Death (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chris Snyder 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

6

March 13, 2007 4c. County of Death 1 COMICO

> Birthplace (State or Foreign Country) MD

3. Time of Death

10d. Inside City Limits

1 Nes 2 No

10g. Citizen of What Country?

U.S.A

14. Race - American Indian Black. White, etc.

Black

2. Date of Death

8. Date of Birth (Month, Day, Year)

02-08-1927

18. Mother's Name (First, Middle, Maiden Surname) HETTIE

RIJENS

Annapolis

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

no

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 Probably 4 Unknown

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

101

100 E. Carroll St. Salisbury Md 21801

**ORIGINAL** 

			For State Registrar	State of Mar	ryland		rtment of F			jiene eg. No.200	7 100
	Physici		1. Decedent's Name (First, Middle	(e, Last) A.Shockley		·			2. Date of Dea Month	th Day Y	3. Time of Do
•	/Medio Examir Funeral		4a Racility Name (If not institution Peninsula Pegill 5. Social Security Number	n, give street and number)  nol Medical  6. Sex 7. Age	(In yrs. la	HER ast birthday)	Sals If Under 1 Year	r Location of Death	8. Date of Birth (Month, Day	4c. County of	Death  MICO  Birthplace (State or F
	Director		218-48-6801 Usual Residence of Decedent	1□M 2⊠F 6	50	Yrs.	Months Days	Hours Min.	Dec. 22	<sup>Yea</sup> r) 1946	Country) MD
	Maryland a-f show ifled at	tor	10a. State 10b. County	cester		Town or Loc					10d. Inside City 1 ☐ Yes 2
	th with the 23a or 28a ust be noti	ral Director	10e. Street and Number 2255 Bird Hill				10f. Zip Code 21864		1	0g. Citizen of Wha	at Country?
3.0036 5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show itical Examiner must <u>be notifled at</u>	by Funeral	11. Marital Status  1 Never Married XXMan 3 Widowed 4 Divorced	If Yes Give			/as Decedent of H Yes, specify Cuba ☐ Yes 2X No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. White
₹ ₩	within 72 ho ene. than "natur he Medical	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or 5+)		(Give I life. D		pation during most of work d)	ing	16b. Kind of Busin	ness/Industry
Maryland 21	be filed tal Hygi d other event, t	To Be Con	17. Father's Name (First, Middle, John B. Johns C	Last)		Supe	rvisor	18. Mother's Name			Department
, 20	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relations Howard L. Shoo	, , , ,				and Number or Run			
(3) altimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 4 → Donation 5 → Other (S	3 □Removal from State Specify)	CE	ace of Dispos emetery, crem tervi	ition (Name of atory or other place 1e Cem.	3-19-	-2007	20c. Location - Cit	y or Town, State
Balt	permit. Pages Department of Important: If if any Injury or once.		21. Signature Funeral Service	Macdeo	$\alpha$	1(	Name and Addre	ss of Facility The	Burhag	e Funera	1 Home
اء	Physicián /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a Inters	tit	ial 2	-	ng, such as cardiac o	or respiratory arm	est,	Approximate Interval Betwe Onset and Dea
3760,	Examiner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Athera Due to (or as a domination of the control	OSC Consequ	evot ence of):	ic Can	idio va	scular	Disea	se
P.O. Box 68760,	hat the death certificate be executed d by the aftending physician and letached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2XCNo 9 □ Unknown	23c. If yes, outcome pf 1 □Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal	death 3 🗆	Ectopic pregnancy Other (specify)	,		23d. Date o Month	f delivery Day Yea
Δ.	ha det	₫	Part II Other significant condition	ons contributing to death but	not recul	ting in the un	tertving cause give	on in Part I	23a Did tol	acco uso contribu	to to the squee of doe

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐ Yes 2 X No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🕅 Inpatient

24a. Was an autopsy performed? 1  Yes 2  X No
---

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 🛣 N	0
27. Manner of Death	
1 🛮 Natural	5 ☐ Pending investigation
2 Accident	investigati
3 ☐ Suicide	6 ☐ Could not

25. Was case referred to medical

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANUPAMA

28h Time of 28c. Injury at Work? 1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☐ Homicide

Completed by

Be

Certification: To

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D006399

S. DIVISION ST. SAUSBUM

29d. Date signed (Month, Day, Year) 2007

BAIH

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

Division or Vital Records, P.O.

VARADARA JAN 31. Date filed (Month, Day, Year)

32. Registrar's Signature

1415

2 ER/Outpatient 3 DOA

State Registrar

State of Maryland / Department of Health and Mental Hygiene) 10094 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10:05 a M 06, 2007 March Fred Thompson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Takoma Park Sligo Creek Nursing & Rehabilitation 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Hours Months 1 X M 2 □ F 1929 North Carolina March 3. 78 **Director** 239-34-4563 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Takoma Park MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20918 238 Apt.1007 7051 Carroll Ave. illed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: þ 3 N Widowed 4 □ Divorced B1ack "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bricklayer/ Masonry Construction 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Emma Thompson Dan Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4106 70th Ave. Landover Hills, MD if itsm 27 i Rhonda Crooms/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State ö pe mit. Page Department o im crtant: if an njury or an t-Ft. Lincoln Cemetery 03/13/2007 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Fuheral Service Licensee Boxa Montamin 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 years Lung Cancer with metastasis **Physician** disease or condition resulting in death) /Medical Examiner 5 years Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai phys the L use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐ Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No Ó 9 Unknown مُ 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner' Hospital: 1 | Inpatient Other: 4 \( \bar{\text{Nursing Home}} \) 5 \( \bar{\text{Residence}} \) 6 \( \bar{\text{Other}} \) Other (Specify) ို 1 Tes 2 X No 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending 1 Natural 1 Tes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated., (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title certifier 29c. License number 1017 March 8, 2007 D21900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carroll Ave. #280 Takoma Park, MD Smith Ho MD 31. Date filed (Month, Day, 32. Registrar's Signature State MAR 13 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2:00<sup>P M</sup> **Physician** Michael Trudgett 2007 March 10. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Germantown 13329 Waterside Circle If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Naromine Australia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F 214-92-1190 May 30, 1944 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural"; or Items 27 s. marked other than "any linjury or other traumatic event. The Maryland once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Germantown **Funeral Director** Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20874 United States 13329 Waterside Circle 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 Never Married 200 Married 1 ☐ Yes 2 No Specify: Caucasian Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Information Technology and Business Strategy Elementary/Secondary (0-12) College (1-4or 5+) Business Management Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laurel Brady ဥ Jerome Trudgett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13329 Waterside Circle, Germantown, MD Anna Trudgett-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3-15-2007 1 ☐ Buria! 2XXCremation 3 ☐ Removal from State Brentwood, Maryland Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sance License 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 Noxu 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer 2 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760. IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 9 I Inknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 29c. License number D45880 3/13/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon & Hwang, M.D., 1396 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Pay, egistrar's Signature State Registrar

Trudgett, Michael

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** TORNEY /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Micomica Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number **Funeral** Days Year 1 □ M 2 F Director MARYL 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Ex-miner must be notified at 1 □Yes 2 No Director hance 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black White etc. 1 Never Married 2

☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BOARD permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Magonee. Elementary/Secondary (0-12) College (1-4or 5+) leachen Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rogers JONA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State Marion, Md 3-25-07 4 □ Donation 5 □ Other (Specify) Charles Ward 917 W. Isabella Salisbury, md 22. Name and Address of Facility Bennie Smith FUNERAL Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Mitastatic Covernma & the brest to bone live, brom **Physician** of years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 241No 1∏ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 21 No 14 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28с. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0014314 March 15,2007

DHMH 17 Rev 1/2001

Registrar

Salisbury MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANPIT P. KLUG. 145 E. Cecuvil Strut,

31. Date filed (Month, Day, Year)

MAR 1 6 2007

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Edward Trout 9:28A James March 23 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 16, 1947 6. Sex Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1**⋈** M 2□ F Maryland 215-46-2077 59 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1x Yes 2 No Hampstead Maryland Carroll 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 21074 3754 Shiloh Rd., Apt. 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) journeyman plumber maintenance 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Henry Trout June Beatrice Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) New Windsor, MD 21776 1216 Overleigh Way Wayne Trout/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/26/2007 Eldersburg, MD Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Sign we of Funeral Service Licen 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anoxic encephalopath weeks Due to (or as a consequence of): prona weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant

requires that the death certificate be executed burial Box 68760, attending properties for use as signed by the a d be detached f P.0. Division or Vital Records, icate has t , page 2 s To the Hospital or Attending Physician:

After within 24 hours after death To the Funeral Director: completely filled in by the

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be

I Hygiene. other than " ent, the Mec

marked other

h and Mental h

Health a

if Item 2

Department of H Important; If Itel any injury or otl once.

**Physician** 

/Medical

Examiner

1 and 2 should be

Pages

Director

Funeral

<u>გ</u>

Completed

Be

Examiner

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn.  1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 □Ectop	ic pregnancy r (specify)			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlyi	ng cause given in Pa	rt I.	23e. Did tobacco u 1 ☐ Yes 2	use contribute to the cause of death?  ☐ No 3 Probably 4 ☐ Unknow
					24a. Was an autopsy performed? 1  Yes 2  Woo	24b. Were autopsy findings availabed prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26. Pla	ace of Death (0	Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4	Nursing Home	5 ☐ Residence	6 NOther (Specify) NO 101
27. Manner of l eath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2	280	d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fa fy)	ctory, office	28f	Location (Street an City or Town, State	nd Number or Rural Route Number, e)

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. CUANTURES, 6701

N. Charles St Towson MD

29d. Date signed (Month, Day, Year)

2007

29c. License number

58303

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Registrar's Signature

Amended Item 16a per F.D. & Items 26 & 29d per Physician 03/15/2007 Carroll Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. wil wj1 State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ernest James Unkart 3 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll 3502 Woodholme Drive Hampstead 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 2/02/1942 7. Age (In vrs. last birthday **Funeral**  Birthplace (State or Foreign Country) 1 X M 2 □ F **Director** 214-42-2037 65 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at Director 1 □Yes 2 No Lowville NY Lewis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6912 Sears Pond Road 13367 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No 1960− If Yes, Give Year or Dates: 1968 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 "natural", or Specify: White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☑ Divorced 1968 Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Superintendent th and Mental Hygiene.

7 Is marked other than '
traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Construction Superintedent Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of James C. Unkart Dorothy Beyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Unkart - Son 916 Century Street, Hampstead, MD 21074 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation 3/15/2007 Hampstead, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Eline Funeral Home, 934 South 21. Signature of Funeral Service Licensee Eline M00723 Main Street, Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No or Attending Physician: To Be 25. Was case referred to medical Daughter's Home 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 1 Tyes il Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MJI 03/13/07 8+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar MAR 15 2007

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylan		artment of H tificate of I			ene [] [] [] g. No.	7 10099
	Physicia		1. Decedent's Name (First, Middle, Last, Mary K	atherine U	mberge	r		2. Date of Death Markch	2 <b>2</b> °, 200 <b>7</b> °	3. Time of Death 0615 <sub>M</sub>
)	/Medic Examin		4a. Facility Name (If not institution, give 8130-A Gas House				Location of Death	1	4c. County of D	ederick
Ī	Funeral Director		5. Social Security Number 6. Sec		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 1,	1949 9.1	Birthplace (State or Foreign Country) Maryland
	Ra-f ehow	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Freder							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the	al Dire	10e. Street and Number 8130-A Gas House	e Pike		10f. Zip Code	2170		g. Citizen of What U . S	Country?
0000	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. Importent: If Item 27 is marked other then "natural; or items 23a or 28a-f ehow empty injury or other traumatic event, the Medical Examinar must be notilled at ance.	by Funeral Director	11. Marital Status  1 Never Married 27 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give \( \) Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify: W	
0-6171	within 72 ho ene. then "natur the wedical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Docup kind of work done of DO NOT use retired teria Wol	during most of wor d)	rking	6b. Kind of Busine	ss/Industry
ana 7	ild be filed lentet Hygi ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) George R. Bender	Sr.	Oare	OCELEC WO	18. Mother's Nan	ne (First, Middle, M Laura M	laiden Sumame)	2002 3) 3 4 4 4 4
, mary	end 2 shou saith and M n 27 is mar	-	19a. Informant's Name/Relationship (7) George E. Umberge	er/Husband	813	30-A Gas I		ural Route Number, ke, Frede	rick, MD	21701
saitimore	Pages 1 tment of He tent: If iter ijury or oth	1	20a. Method of Disposition  1	Removal from State Mt	emetery crei			n 26, 200		rick, MD 2170
g	Depar Depar Impor eny ir		21. Signature of Funeral Service Licens  22. Signature of Funeral Service Licens  23a. Part1. Enter the disease, or comp	Easfard M	1	106 E	ast Churc		, Freder	ick, MD 21701
)	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a conseq	luence of):			rt Failur cardial I		interval Between onset and beat of this and beat of this are the second of the second
8/60, ~	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)	juence of):					
O. Box 6	The law requires thet the death certificate has been signed by the attending plaga 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ▼No 9 □Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3	□Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
7	quires thet n signed b	Ď	Part II. Dther significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I.			e to the cause of death?  Probably 4 Unknown
Vital Records,		Completed						24a. Was ar autops perform 1 Yes 2	y prior	
<u> </u>	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		25 DOA OT	oc.	ath (Check only one		
ö	this ald	- T	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o	III 3LI DOA	4 🗆 Nursing r	lome 5 Reside		Specify)
	l or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Year)  28e. Place of Injury - At houilding, etc. (Speci	Injury ome, farm, st	M 1	rk? Yes 2 □ No		reet and Number o	r Rural Route Number,
۵	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur	Medical Cer	29a. Certifier 1 Check only 2 Medical Exam		owledge, deat	th occurred at the ti	me, date and place	e, and due to the ca	use(s) and manne	r as stated. due to the cause(s)
)	To the within: To the comple	Med	29b. Signature and title of dertifler	and main states.		29c. Licens	se number	26	9d. Date signed (M March	onth, Day, Year) 22, 2007
	10		30. Name and address of person who o						01707	
	_	ate	31. Date filed (Month, Day, Year)	a1, N., 110	Rauchi eture	ian's Lan	e, Frede	rick, MI)	7.1.7()]	

07-01840 Wayne Delano Wilson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

			1- For State Registrar  1- For State Registrar  1- For State Registrar  1- For State Registrar	ZUU.	1010
	Physicia	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death		3. Time of Death
edical	Exami	ner	VVC TIE DETATIO DO 138V		1621 hrs
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  3560 Height Road  Cambridge	4c. County of Death  Dorchester	
F	uneral			MM/DD/YYYY) 9. Birth	nplace (State or
	irector		219-42-8533 17M 2 F 6/ Yrs. Months Days Hours Min. May 8	Foreign	1
		ŀ	Usual Residence of Decedent	1972	Maryland
	* any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
land.	28a-f show	호	NID Dorchester Cambridge		1 Yes 2 V No
Man	23a or 28a-f sho notified at once.	<u>ie</u>	10g. Street and Number 10f. Zip Code 10g.	Citizen of What Coun	try?
7	s 23a notif	Funeral Director	3560 Height Road 2/6/3  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ	an Indian, Black,
7	item ust b	Ē	1 Never Married 2 Married Armed Forces? 1 V Yes 2 No	White, etc.	
3	al", or	by F		Specify: B10	ack
	'natur Exam	ed t	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	6b. Kind of Business/Ir	dustry
36	han	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  Maintenance Worker	Plastics	Tinde Chris
5-0036	fygiene. other than he Medica	ĕ	Maintenance Worker   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maio	den Surname)	+11907114
2121£	Mental H marked c event, r	Be	Sherwood Perry athedia Bla	nche W	:150n
D 21	nd Me is ma atic e	7	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Numb	4	Zip Code)
, MD 21215-0036 CCC and 3 should be filed within 72 hours after clean with the Manufand	og 53 rand and Mental Hygiene. 1: If item 27 is marked other than 'other traumatic event, he Medical	1000	Ruby Wilson 3560 Height Road Cambr  20a. Method of Disposition 20b. Place of Disposition (Name of Semetery, Date 20	Oc. Legation - City or	) i 2/6/5 Fown, State
Baltimore,	tof H	ш	1 V Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Aireys Centerent 3/17/07	Carl 1	11000010
Baltin					
ä	Depart Impor injury	200	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Henry Funeral Home, P. A.  SIO WOShington St. Can	abridge, N	10.2/6/3
	sician		23a Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a rdiac or respiratory arrest, failure. List only one cause on each line.	shock, of femi	Approximate Interval Between Onset and
	ledical. aminer		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease or condition resulting in death)		Death
			h		
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
		Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
potenti	signed by the attending physician and be detached for use as the burial - transit	al E	d.		
60,	stcian	Medical	UNPENDED AMENDED	23d. Date of delivery	
876	ng phy as the	m/M	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		ay Year
Box 687	attendi or use	Physician/	past 12 months:  4 Pregnant at time of death 5 Other (Specify)		
Ö.	by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	acco use contribute to t	he cause of death?
Р.О	igned be det	d by		2 No 3 Prob	ably 4 🗹 Unknown
of Vital Records,	been s	Completed	24a. Was an autopsy		opsy findings available ompletion of cause of
oca -	this certificate has been a director, page 2 should	Ĕ	performe	ed? death?	-
<u> </u>	artifica tor, pa	UΨ	(Check only one)		
Z K	this c	70 B	O 1 Yes 2 No Inpatient 2 EK/Outpatient 3 DOA 4 Nursing Home 5 Re	esidence 6 Other	Scene
ور آ	After funeral			v injury occurred	
Division	death ector: by the	cati	2 Accident Pending Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street)	eet and Number or Ru	ral Route Number, City
Divi	ipital of Attending Fill ours after death. Iteral Director: After the	Certification:	3 Suicide 6 Could not be determined (Specify)		
	riospi 24 hou Funer tely fil			s) and manner as state	ed.
Division of Vital Records, P.O. Box 68760,	o the Hospital of Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.		
	, [ 0	Ž		29d. Date signed (Mor March 9, 2007	ntn, Day, Year)
			The ades M. F. & JM, weel.		
			30. Name and address of person who completed deude of death (Item 23a)  Theodore M. King, Jr., MD.   Assistant Medical Examiner		
العزيد		tate	22 Pull diverse Signature		

			For State Registrar	State of Marylar		artment of		nd Me		iene	07	10101
1.	Physici		Decedent's Name (First, Middle, L Trene	Last) Wilson					Date of Deat		Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town	, or Location of			-	inty of Death	12.00
	LXdiiiii	ė.	Mariner Health	of Greater Laur	re1	Lau	re1			P	rince	George's
*	Funeral	3		. Sex 7. Age (In yrs. 1 ☐ M 2 ☒ F	last birthday) Yrs.	If Under 1 Yea Months Day		Min.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
91.5	Director		198-18-9479 Usual Residence of Decedent	83	115.			D	ec. 1,	1923	Penn	sylvania
	be filed within 72 hours after deeth with the Maryland tal Hyglene. d other than "natural", or items 23a or 28e-f ehow event. The Medical Examiner must be notified at	or	10a. State 10b. County Maryland Prince		ty, Town or Lo							10d. Inside City Limits  Y☐ Yes 2 ☐ No
	28e-f	rect	10e. Street and Number			10f. Zip Code	9		1	0g. Citizen	of What Cou	ntry?
	h with	Funeral Director	4900 Berwyn Roa	d		20	0740				USA	
	ems ?	Iner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent o	f Hispanic Orig	gin? (Specif	y Yes or No-		Race - Ameri Black, White	
20	72 hours after natural; or Ite	by Fu	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced			1□Yes 2⊠N					ecity: Wh:	
2-003p	2 hour		15. Decedent's	Education	16a. Dece	dent's Usual Occ	cupation			16b. Kind o	of Business/Ir	ndustry
בות	thin 7: en "n	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	life.	kind of work dor DO NOT use reti	ired)		D	ept. o	of Hum	an Services
7	filed within 7 Hygiene.  Other then "rent, in wed	Con	12		Human	Service						ernment
yland		Be	17. Father's Name (First, Middle, La John Wilson	ist)					First, Middle, I (known)	Maiden Sun	nam <i>e)</i>	
	should nd Mer marke	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stre				. City or To	wn. State. Zi	o Code)
Z	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Michael Wilson -			Berwyn						0-2111
e G	iges 1 and of the control of the con	1 2	20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other p		Dat			on - City or T	
Ĕ	Parie		1 ⊠Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Micha	el's Cer	metery3	3/17/0	7 S		doah,	
Baltimore,	permit. Depertm Importa eny inju		21. Signature of Funeral Sarvice Li	en ee		2. Name and Add			P.A.			more Ave. e, MD 20781
,	- J. 1880		23a. Part 1. Enter the disease, or conshipled shock, or heart failure. List of	omplications that caused the dea								Approximate Interval Between
	Physician		Immediate Cause (Final disease/or condition	. Anterio	Sclo	notic (	anded	Vascu	ear	Dese	are	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse								J. J. 4
	. 7	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):							
	uted 3 ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events		1							
o Î	be executed icien and burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):							
8/60,		cal		d								
×	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancy					004	Data of dati	
X P O	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 □ Live birth 2 □ Fet 4 □ Pregnant at time of	al death 3	☐Ectopic pregna				230.	Date of delice Month	Day Year
o.	at the de by the a stached i	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
a, J	gned be de	by P	Part II. Other significant condition	s contributing to death but not re	sulting in the u	/	1.			•		the cause of death?
ecords,	w requir been si should I	Completed	- Ola C	our we resume		Accid	and		1 🗆 Y	es 2NN	o 3∐Pro	bably 4 DUnknown
ř	: The law cete hes b . page 2 si	mpie							24a. Was a autops	SV	4b. Were aut prior to c	opsy findings available ompletion of cause of
			OS Man ann arland to madical					. = 2 2 1		med? 2)No	1 🗆 Yes	254 No
=	ysicien: 1 is certifice director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 X No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Othor		Check only or 5 ☐ Reside		Other (Snec	rfu)
2	ding Phy h. After thi funeral (		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		njury at Nork?		d. Describe h			
000	endin eath. or: Af	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	tion	,,		☐Yes 2☐I	No				
Division of Vital	Hospitel or Attending Physicien: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st ify)	reet, factory, offic	се	28	f. Location (S. City or Town	treet and Ni n, State)	umber or Ru	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medicai (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my kn xaminer: On the basis of examin and manner stated.	iowledge, deal ation and/or in	th occurred at the exestigation, in m	e time, date an	d place, an th occurred	d due to the clat the time, d	ause(s) and late and pla	d manner as ice, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	- A -	.445		ense number		1		gned (Month	
)	7			4500 C	Wi	7 7	0024	721	1	Narch	136	2007
-	(10)		30. Name and address of person w	14333 Laure	1 Bowie	e Rouc	(Sta	208	Laurel	Q W	18	20708
7.5	Sta Regist	ate rar	31. Date filed (Month, Day, Yeal) MAR 1 6 200	32. Registrar's Sign	poed	v						

1-3	For State Registrar	State of Marylar		artment of F <i>rtificate of</i> a			giene	07 10102
1. De	ecedent's Name (First, Middle, Las	st)			-	2. Date of De	ath	3. Time of Death
Physician /Medical C1	layton S.	Wilson, Sr				Month	4, 2007	4:30 A <sup>M</sup>
Syaminar 4a. F.	Facility Name (If not institution, give oodside Nursing	street and number) Home		4b. City, Town, o Silver	r Location of Death Spring	1	4c. County Montgo	of Death
Funeral 5. So 24	ocial Security Number 6. S 45-12-4595 1	9x 7. Age (In yrs 1 M 2 F 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11-20-	ly, Year)	9. Birthplace (State or Foreign Country) Burlington, NC
Usua	al Residence of Decedent					11-20-	-1920	
Mod 10a.	State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
Ba-f o	MD Montgome	ry S11	ver Sp					
Direction of the second	Street and Number			10f. Zip Code			10g. Citizen of V	
of the man	01 Second Ave	12. Was Decedent Ever in U	J.S. 13.	20910 Was Decedent of H	lispanic Origin? (Si	pecify Yes or No		d States e - American Indian.
2 S S S S S S S S S S S S S S S S S S S	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	Specify:	o Rican, etc.)		k, White, etc. Black
2 ho	15. Decedent's Ec		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation	kına	16b. Kind of Bu	siness/Industry
ed within 72 ho ygiene. The Marical I. I. Ihe Marical I. Completed	lementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired k Driver	d)	King	Private	
Con Con	12 Father's Name (First, Middle, Last)		Truc	r DIIVEI	40 Markada Nas	- Cies Middle	, Maiden Sumam	
Mental Hy Mental	lvis Pennix					, ,	, Maiden Surnam	6)
A A Marken of Ma	L Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street	Josey W:		er. City or Town.	State, Zip Code)
B1	lanche G. Wilson		1	Sargent				
20a.	Nethod of Disposition	Helitovat Itolii State		osition (Name of matory or other place	1	Date		City or Town, State
Dealth In Orange Service Control of Manager Serv	4 □Donation 5 □Other (Specify Signature of Funeral Services	. +01		oln Cemet 2. Name and Addre			Brentwo	
Dermir Dopar Impoor Impoor Impoor Impoor	Suhat Chan	4	1					, MD 20722
Physician Imm	a. Part1. Enter the disease, or com shock, or heart failure. List only nediate Cause (Final	olications that caused the dea one cause on each line. Failure to			ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death months
	ease or condition ulting in death)	Due to (or as a conse	quence of):					MOHLIIS
Sequif and	quentially list conditions,	b. Due to (or as a conse						
Examinary (and that the cause of the cause o	quentially list conditions, ny, leading to immediate se. Enter Underlying use (Disease or injury i initiated events							
ireate be executed physicien and physicien and stree burial-transit edical Examin	ulting in death) Last	Due to (or as a conse	quence of):					
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death certification of the standing of for use a standing of the standing of t	EMALE:  . Was decedent pregnant in the past 12 months?  1 Yes 2 No	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3[	□Ectopic pregnancy □ Other (specify)	/		23d. Dat	e of delivery nth Day Year
Phy to detach the bat the betach	9 Unknown  II. Other significant conditions c	ontributing to death but not re	sulting in the I	Inderhing cause div	en in Part I	23a Did t	ohacco use conti	ribute to the cause of death?
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The law requires the law requires the law requirements the law requireme						24a. Was auto perio 1 \( \text{Yes} \)	psy primed?	Nere autopsy findings available prior to completion of cause of leath?
25. V	Was case referred to medical examiner?				26. Place of Dea		21	
Physic ral direction 1	1 ☐ Yes 2 ☐XNo		ER/Outpatie		4 X Nursing H	ome 5 Resi	dence 6 □Oth	er (Specify)
O T Affect Affect 1 52. V	Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wor		28d. Describe	how injury occurr	ed
Attending ar death.  • ctor: Attending by the fune liffication	2 Accident investigation 3 Suicide 6 Could not be		nome farm st		Yes 2 □ No	28f Location /	Street and Numb	er or Rural Route Number,
tel or Attending Fig. 18 and 1	4 Homicide determined	building, etc. (Spec	ify)	reet, factory, office		City or To	wn, State)	or or right route regriber,
	Certifier Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred at the tire evestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
Within To the Complete Some Solution To the	. Signature and title of certifier	0		29c. Licens	e number		29d. Date signed	i (Month, Day, Year)
	> Awei	2000 1 20	D nu	) D382	262		March	9, 2007
13/	Name and address of person who . Mendhiratta, I			Print) Blvd. Su	ite 330	Rockvi	11e, MD	
State 31. E Registrar	Date filed (Month, Day, Year) MAR 1 3 2007	32. Registrar's Sign						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Whitfield John -8:30 P. March 5. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgorery SIlver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1⊠M 2□F 43 578-04-9264 Yrs Director Washington, D.C. August 27, Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Washington D.C. 1 ☑ Yes 2 ☐ No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code death with 20019 U.S.A. 240 37th Place, S.E. 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: ural", or items 2 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Annie Ruth Livingston Willie Lee Whitfield, Sr. 2 b. Mailing Address (Street and Number or Rural Route Number. City of Town, State, Zip Code) 240 37th Place, S.E. Washington, D.C. 20019 19a. Informant's Name/Relationship (Type. Print) Tawana Doughtie (SIster) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: if ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory, Inc. March 19, 2007 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signa of Funeral Service Licenses 4339 Hunt Place, N.E. Washington, D.C. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acquired Immune Deficiency Syndrome **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter thirderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be Brain Mass 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy certificate 2 **M**lo 1□ Yes Hospital or Attending Physician: after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 20 No ۲ 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred . Injury at Work? Injury 5 ☐ Pending investigation 1 🔯 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and fitte of o 29c. License number 29d. Date signed (Month, Day, Year) DR63579 March 7, 2007

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maria J. Tayag, M.D.

1500 Forest Glen Road Silver Spring, Maryland 20910

			Please  1	State of Man	yland / Depa		lealth and M	lental Hyg	•	10104
ı	Physici		1. Decedent's Name (First, Middle, La Carol T. William	•				2. Date of Deal Month		3. Time of Death  3. 3. A M
	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County of Deat	
Ī	Funeral Director		5. Social Security Number 6. S		n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 21,	9. Birt 1935 Ne	hplace (State or Foreign untry) W York
	aryland ehow	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 1 No
	death with the Maryland ms 23a or 28a-f show r must be roulified at	Director	MD Howard  10e. Street and Number  2749 Westminster		Ellicott	10f. Zip Code 21043		1	Og. Citizen of What Co	ountry?
-0036	n 72 hours after death with the Marylan "neturel", or items 23a or 28a-1 show tedical Examinan must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces?  1 Yes 25 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 140	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	rican Indian,
2	72 hou		15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of work	sing	16b. Kind of Business	Industry
777	be filed within ital Hygiene. id other then " event, it e Me	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las.	College (1-4or 5+)		DO NOT use retired	n. Assis		Bio Tech C	ompany
Ĕ	e	To Be	Lawrence Katz	,			Lillian			
Jar	and and eur	ľ	19a. Informant's Name/Relationship Scott L. William						r, City or Town, State, .	
<b>1</b> 0	Pages 1 end 2 nent of Health int: if item 27 iry or other to		20a. Method of Disposition 1   Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Speci	_Removal from State	20b. Place of Dispo cemetery, crei Crest La	osition (Name of matory or other place wn Mem. C			20c. Location - City or Marriottsv	
Balt	permit. Pages Department of P important: if ite eny injury or of		21. Signature of Funeral Service Lice	· 11 9/1/ 11					tzke's Fam icott City	ily FH Inc. , MD 21043
	nysician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.		ter the mode of dyin	ng, such as cardiac		rest,	Approximate Interval Between Onset and Death MOAHAS
, 00,	be executed sicien and burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a of Due to (or a) Due to (o	consequence of):					
.C. Box 6	of the death certificate I by the attending physicached for use as the totached for use as the totache	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ ₹0 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of de Month	livery Day Year
ecords, r	es the igned be de	۵	Part II. Other significant conditions Per foraled	contributing to death but Duodenal		underlying cause giv	ren in Part I.	Ì	ebacco use contribute to	o the cause of death?
Hec	The law ete hes t page 2 s	Completed						24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of
VII	Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital: 1 Dunation	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Dea		ne) lence 6 □Other <i>(Spe</i>	south)
	D 0 0		27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day )		of 28c, Injur Wor	y at k?		ow injury occurred	ony,
DIVISION	or Attantier deat lirector: n by the	Certification;	2 Accident investigation 3 Suicide 6 Could not determined	De Class of Injur	r - At home, farm, st (Specify)		Yes 2 □ No	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number.
	Hospita 4 hours Funera ely fille	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best of aminar: On the basis of e	xamination and/or in	th occurred at the timestigation, in my o	me, date and place, ppinion, death occur	, and due to the c rred at the time, c	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the To the Complet	Me	29b. Signature and title of certifier	W HD		29c. Licens	14602		29d. Date signed (Mon	
_	E.G.		30. Name and address of person who Kolli Rameth	900S a	atoms av		imbre, m	nD 212	29	
	Sta	ate	31. Date filed (Month, Day, Year) MAR 1 6	2007 32. Registrar	s Signature	hack .				

DHMH 17 Rev 1/2001

WILLIAMS, CAROL T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per dr. 2865.03/29/07dhb
Amend item #6 sher FH/wichd/d1s/03-12-07

Amended items Registrer #2820b per DR&FH/wichd/03-12-07/1/2018 of Death

Reg. No. 7 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death 03-08-2007 Birdie L. Williams **Physician** Brown 0830 M <del>ष्ट्रि क्रेट</del> /Medical Facility Name (If not institution, give 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci Kaurelwood are Center ElKton May and if Under 24 Hrs 8. Date 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 83-22-6015 Yrs Pendleton SC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28e-f ehov Exeminer must be notified at 1 Pes 2 No Funeral Director ANDERSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 533 RIVE Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ₩6 Specify. þ 3 Dividowed 4 □ Divorced CACK "natural" Completed the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSE REEDER 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be MODINSON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19977 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Health ar Important: if Item 27 is eny injury or other trau from State 20b. Place of Disposition (Name of Foreign HTP) and Creins (1881) Date 20a. Method of Disposition 20c. Location - City or Town, State Philadelphia, PA 1 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3 remature of Fune. I Service License West ISABELLA SI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 176PSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed Unus Due to (or as a consequence of) attending physicien for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 ☐ Yes \_2☐ No 1 Yes 2DNo is after deau...
rai Director. After this cer...
rai by the funeral director, pr 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: Mursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ Ño 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Vionth, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Ph (cin): To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exame in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and master stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 540 8NAL 30. Nam and address of erson who ed cause of death (Item 23a) (Type, Print) CINRCHMANS 31. Date filed (Month, Day, Year)
MAR 1 2 32. pagistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Registrar

31. Date filed (Month, Day, Year)

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			State of Maryland / Department of Health and Mental Hygiene									
		1 - State Registrar				Certificate of Death			Reg. No.			
	Physicia	_	1. Decedent's Name (First, Middle, Last)					2. Date of Death Day Year 3. Time of Death (				
	/Medical								3-28 200 4c. County of Dea		5.44 1.	
j	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, c					n	The state of the s	LIII	1000	
153	a same and a		FRANKlin Squa	7. Age (In yrs. Ia	ot hirthday)	If Under 1 Yea	edale r   If Under 24 Hrs	8. Date of Birt	h		place (State or Foreign	
	Funeral		5. Social Security Number 6. Sex 1 □ M	2 🗗 71	Yrs.	Months Days			, 1 <sup>Year)</sup>	Mar	yland	
	Director	L	Usual Residence of Decedent					12002			,	
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. Or it fleem 271s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code 21 221			10g. Citizen o		ntry?	
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21215-0036		by Funeral	11. Marital Status 12.  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (stan, Mexican, Puer ban, Mexican, Puer o <i>Sp</i> ec <i>ify:</i>	Specify Yes or No to Rican, etc.)		ace - Americ lack, White, cify: Whi	etc.	
ş	tura cal E	pe				16a. Decedent's Usual Occupation			16b. Kind of Business/Industry			
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717	d with giene r tha the l	Completed	10			Homemak		Own Home				
פַ	othe	To Be C	17. Father's Name (First, Middle, Last)						ne (First, Middle, Maiden Surname)			
<u> </u>	should be ind Mental marked o		Roy Clarence Feit			Elizabeth Hildab						
Maryland	LT III		19a. Informant's Name/Relationship (Type		reet and Number or Rural Route Number, City or Town, State, Zip Code) Ine Baltimore, Maryland 21221							
, V			James Burton (Husbai					Date Plat	20c. Location		'our State	
o e			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State	ace of Dispo emetery, crei	sition (Name of matory or other p	lace)				Maryland	
Ē			4 ☐ Donation 5 ☐ Other (Specify)	HO.	-		ardens 3/	31/2007	Daitin	iore,	Marylana	
Baltimore,	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 21221									
1	Physician /Medical Examiner		23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyl shock, or heart failure. List only one cause on each line.									
		i Y	Immediate Cause (Final disease or condition			Archythmias			5-10			
			resulting in death)	Due to (or as a consequ	uence of):	V		0- 0-0	ر آهن	da	15-20 mmi-	
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8760	cate be executed physician and the burial-transit	E E			,							
87	physics the	dical	d.									
× 6	ding	Physician/Me	IF FEMALE: 230				23d. Date of delivery		very			
Box	death certific e attending p d for use as	cian	23b. Was decedent pregnant in the past 12 months?					Month Day Year				
<u>Р</u>	The law requires that the death certific tte has been signed by the attending F tage 2 should be detached for use as	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown									
J.										ontribute to	the cause of death?	
g	quires n sign ald be	d by	HTN, GERD.						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
<del>ဂ</del>	w rec	Completed							24a. Was an 24b. Were autopsy findings			
æ	The lavate has	ᄩ						- auto perf 1⊟ Yes	autopsy prior to completion of ca death?			
g	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Ö	25. Was case referred to medical				26. Place of D	eath Check onl		1,00	20110	
>		0 B	evaminer?	spital: 1 Inpatient 2	Other:				forme 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
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o	nding tth. r: Aft	atio	1 ☑ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation			M 1 ☐ Yes 2 ☐ No						
Division or Vital Records,	5 # 5 E	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ury - At home, farm, street, factory, office c. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C									stated. to the cause(s)	
	o the ithin i o the omple	Mec	29b. Signature and title of certifier	ense number	29d. Date signed (Month, Day, Year) 4 03-29-2007.							
	F X F 8		M/S	-3875								
	1		29b. Signature and title of certifier  M.D.  D-38754  03-29-2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MALIKA BASEM: 709. CASTERN BLVD - MID-21221							,		
	4	22 Periotral's Signature									1221.	
	St	ate	MAD 9 A 200		k L	10 and 9						

DHMH 17 Rev 1/2001

Jean Burton

State of Maryland / Department of Health and Mental Hygiene 2 1 7 For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Joseph R. Beard, III 12:05 03 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Multi-Care Center Baltimore 8. Date of Birth (Month, Day, Year) NOV. 16, 1942 ff Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F 260-64-6107 64 Yrs. Georgía Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "netural", or items 23e or 28a-f show ant; or items 25e or 28a-f show any or other freumatic event, Ite Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2X No Maryland Directo Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5632 Lightspun Lane 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S.A.C.A.A. Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Beard, Jr. Madora Harris ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Beard (Wife) 5632 Lightspun Lane Columbia, MD 21045 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Crownsviile other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 3-30-2007 Crownsville, Maryland Veterans Cemetery 21. Signature of Funeral Service 1 Witzke Funeral Homes, 5555 Twin Knolls Koad Inc. Columbia, MD 21045 Tader 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA ADVANCED un known /Medical Due to (or as a consequence of). **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? ģ Hypertension SEIZUre 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification; 5 Pending investigation 1 Natural 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours a 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 0 D0054056 3/27/07 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MT Royal Ave Belt NO Dalicet Saluje mcst 1600 32.\_Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARCH WALTER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BACTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 214-26-2062 Director October 3, 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1√Yes 2 No Director N/A Baltimore Maryland death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 USA 21224 501 South Decker Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items any Injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. Specify: þ 3 ☐Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Tavern Owner 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Elliott Briggs Loretta Boswell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Briggs Brother 604 Ross Street, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 31, Sacred Heart of Jesus Cen. 2007 Dundalk, Maryland Connelly Funeral Home Of Dundlak, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) REPIRATORY **Physician** month /Medical Due to (or as a consequence of): Examiner NEUMONII Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 2 **M** No Hospital or Attending Physiclan: after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manur of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral Completely filled filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

VAZMIN 31. Date filed (Month, Day, Year)

MAR 3 0 2007

DHMH 17 Rev 1/2001

EASTERN AVENUE, BALTIMORE MD 21224

30. Name and address of person who completed cause advant (Item 23a) (Type, Print) VAZMIN MORANES, M.D., M.S. 4940

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:30 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Universit Moryland 3altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 ☐ F Yrs. Maryland 213-14-8813 22,1921 Feb. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Instit if item 27 is marked other than "natural", or items 23a or 28a-f show mut: if item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Directo Lutherville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 116 Croftlev 21093 Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Supply Co. President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Stifler Anna Α. Benson ျှ Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 116 Croftley Road Lutherville, Maryland Genevieve Benson 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Duranety Valley 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-31-2007 Timonium Maryland Memorial Gardens 21. Signature of Fu Proservice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subdura Lrs 710 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examine be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9☐Unknown 9 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ğ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? perform 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: Hospital: 1 Impatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After t Certification: 5 Pending investigation 1 ☐ Matural 3:00 am • Hospital or At.
• ours after death.
• Director: AF 07 1 ☐ Yes 2 ☑ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) - At home, farm, street, factory, office Lutharrille 4 Homicide 116 Croftly Rel Home within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 27/07 1476435-18047 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solt, mora 22 Ulmer MD St. Charl 61ech

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State Registrar 31, Date filed (Month, Day,

ORIGINAL

32 Registrar's Signature

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State

Registrar

31. Date filed (Month, Day,

Year)

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\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1**- State Amend #26, perMD, g865, 3/30/07IT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 2007 **Physician** BEASON WILLIAM -26-7:20 A M /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ounty of Death **Examiner** 9. Birthplace (State or Foreign Country) trince If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day) **Funeral** Months Days Hours 242-28-2685 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** seorges · 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or Sass wood 20+08 Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Tes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify. 3 Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) rinci Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil trent of Health and Mental H tant: If Item 27 is marked oth reason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau
once, 11518 Basswood 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State re of Funeral Service 21. Sign 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 47 le, Butonic, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO-PULMONARY ARREST **Physician** /Medical Due to (or as a consequence of) **Examiner** MYOCARDIAL INFARCTION a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed DIABETES MELLITUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy HYPERTENSION perforn this certificate 1∐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ En/O nt 3□ DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAK, 7300 VANDUSEN RD, LAUREL, MD Z0707

Registrar DHMH 17 Rev 1/2001

State

ABDUL

31. Date filed (Month, Day, Year)

30

2007

32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 2. Register's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 1:30P M FREEMAN EDDIE MARCH 27 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVENWOOD NURSING & REHAB. CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 M 2□ F 244-76-8268 63 NC Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. inside City Limits 10a. State Yes 2 No MD BALTIMORE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò þe 315 S. GILMOR STREET 21223 USA 23a r than "natural", or items 23s the Medical Examiner must Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: à 3 X Widowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 FLORENE BROADWAY WILLIAM BANKS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) t of Health : ANNIE SIMPSON/SISTER 4633 COLHERNE RD. BALTIMORE, MD 21229 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If any Injury or once. **METRO CREMATORY** 3-28-2007 BALTIMORE, MARYLAND 21. Sonative of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for as a consequence of) MMUNE DEFICIENCY SYNDROME Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of) physician Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9☐Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury 28b. Time of 28c. Injury at Work? after death. 27. Manper of Death 28d. Describe how injury occurred Naturai (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours a

with

death v

filed within 72 hours after

pe

Pages 1 and 2 should

3altimore, Maryland 21215-0036

Certification:

completely filled in by the Medical

State Registrar

31. Date filed (Month, Day, Year)

29a, Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 6

Name and address of person who completed cause of death (Item 23a) (Type, Print) 82)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number O.C.M.E. March 22, 2007  30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 3 Registrar's Signature	O. Enat the od by the etached		Part II. Other significant cor	ditions contributing	to death be	ut not result	ting in the ur	nderlying ca	use give	en in Part	I.	l				
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Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 33. Registrar's Signature			Mulina /2	earrell,	MI				D.C.M	.E.			Marc	:n 22, 200	J <i>1</i>	
State 31. Date filed (Month, Day, Year) 33. Registrar's Signature	\$		1					enn Stre	et, Ba	ltimore,	MD 2	1201				
Registrar MAR 3 0 2007	S		31. Date filed (Month, Day, Ye	(ar) 31	Registrar's	Signature	Some	K)				-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar State of Maryland / Department of Health and Mental Hygiene Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** 30:33 BURNS MARCH 2007 33 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 8. Date of Birth (Month, Day, Year)
July 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 79 219 22 7219 Maryland Director 1927 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Baltimore Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Hammonds Lane U.S.A. 21225 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 🛐 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward C. Smith Anna Seifert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Mayo / Daughter 305 - 6th Avenue N.E. Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 3/27/2007 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Suneral Service Licensee 21. Signature Gonce\_Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 P 11. Enter the diseas: complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. Link on vione cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sitecic SEVERE SEPTIC DAYS /Medical Due to (or as a consequence of): Examiner 5 days Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Box 68760, and Due to (or as a consequence of) physician at s the burial-t Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No this certificate has 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Injury 5 ☐ Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES - 000 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTHOUY J SCHAEFTER NORTH BALTIMORE, MD 21387-9106 600 WOLFE STREET 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28, 2007 4c. County of Death March VISIM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore timore Haven 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

December 16,1932 West Virginia Social Security Number Age (In yrs. last birthday, **Funeral** Hours 1. M 2 □ F 217-30-131 Director Usual Residence of Decede 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County пs 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☑ No Baltimore Dundalk Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 8169 Del Haven Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 27 Is marked other than "natural", or Iten traumatic event, the Medical Examiner Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse 10 years Wireman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Wilhelm Walter Carder ۵ Baltimore, Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 7117 Martell Avenue, Dundalk, MD. 21222 Dolores Carder wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20c. Location - City or Town, State 20a. Method of Disposition March 29, permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City, MD. 2007 21. Signature of Fundral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Vel 23a. Fart1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nknown **Physician** araid Muopan disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) o 9 Unknown signed by to be to be to be the detach م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð Ibstructive Pulmonary Disease 1 | Yes 2 | No 3 | Probably 4 Unknown Completed peen bronary Artery Disease, Kidney Failure, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes liabetes certificate or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? After Certification: Division or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 60

State Registrar

DHMH 17 Rev 1/2001

Eugene Craig, M. D., VR Maryland Hearth Care System, Perry Point, MD 2PO2
31. Date filed (Month, Day, Jear)
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-02173 Clara Nicole Car	npbe	Please Type or Print in Black Indelible Ink. Ensues	ure All Copie and Mental Hy	<b>s Are Leg</b> /giene	ible. 200	7 1011
	ل	1- For State Certificate of Death Registrar			J. No.	
Physicia Modical Exami	-	1. Decedent's Name (First, Middle,Last)  Clara Nicole Campbell		<ol> <li>Date of Death Month March 21, 2</li> </ol>	Day Year	3. Time of Death 0105 hrs
			or Location of Death	171017 21, 2	4c. County of Dear	th
Funeral		University Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y.		8 Date of Birth	N/A	irtholace (State or
Director	- 1		ays Hours Min.	7/23/1	Fore	
ŕ	ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		17/20/1	.001	10d Inside City Limits
ne Maryland or 28a-f show any fied at once.	_	Md Anne Arundel Glen Burnie				1 Yes 2 No
Maryla 28a-f	ecto	10e. Street and Number 10f. Zip Code	•	100	Citizen of What Cou	untry?
ith the 23a or notifie	ä	7775 Monaghan Road 21060			USA	
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director		nispanic Origin? (Sp pan, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,
s after c ral", ou	by F	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2XXX			Specify: B1	
2 hours	ete	Decedent's Education (Specify only highest grade completed)      Elementary/Secondary (0-12)      College (1-4 or 5+)      College (1-4 or 5+)      College (1-4 or 5+)			16b. Kind of Business	/Industry
036 within 7 ene. er than Medica	Completed	12 Cashier			Fast Foo	ods
215-( e filed v al Hygi ced oth	Be Co	17. Father's Name (First, Middle, Last)  Solomon Campbell, Jr.	18. Mother's Name Rita R		*	
212 nould brid Ment is mark	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Str	reet and Number or R	ural Route Numb	er, City or Town, Stat	
, MC and 2 sh ealth an	-	Solomon Campbell, Jr. 7775 Monagh			Burnie, Mo	
nore ages 1: nt of H. nt: If it		1 Burial 2 XCremation 3 Removal from State crematory or other place)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	}	4 Denation 5 Other Specify: Metro Cremato			Catonsvi	
	_{	23a, Part I. When the disease, or complications that caused the death. Dollate the mode of dying	BRothers 1taw Plac	ce, Bal	timore;	Md. 21217
Physician /Medical		failure List only one cause on each line.	ng, such as cardiac or	respiratory arres	st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):				
- "	e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
yl	amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				ļ
and transit	ω	d.				
O, s be exersician a	edic	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, rate or Attending Physician: The law requires that the death certificate by rate death.  The law force of the state of		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna	ncy	23d. Date of delive Month	ry Day Year
Sox ( leath ce e attend for use	/sici	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)				
O. E at the d d by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
S, P. puires the signer of the	ed by			1 Yes		bably 4 Unknown
Cord law rec has bee	Completed			24a. Was ar autops perform	y prior to ned? death?	utopsy findings available completion of cause of
l Re n: The tificate or, page	e Cor	25 Was case referred to medical 26 Pla	ace of Death (Check o	1 Yes 2	No1 ✓ \	res 2 No
Vita hysician this cer	8	examiner?  1 ✓ Yes 2 No  Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 DOA	Othor		tesidence 6 Othe	er:
n of ding Pl	on: T	1 Natural Day Year) 0005 hrs	njury at Work? Yes 2 ✔ No		ow injury occurred strian struck by	train
Divisior ospital or Attenc hours after death meral Director:	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office		28f. Location (St	reet and Number or R	ural Route Number, City
Div pital or ours after eral Di	ertif	3 Suicide 6 Could not be determined (Specify) railroad tracks		or Town, Sta 698 W. Pataps	ate) co Avenue, Baltimo	ore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, one)  Medical Examiner: On the basis of examination and/or investigation, in my opin				
To the within To the comp	Medical	and manner stated	ense number	J. J	29d Date signed (M	
		Theodor Il WATER ON	C.M.E.		March 21, 2007	
5	1	30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Ir. M.D. Appropriate Medical Evaminar. 111 Page 1	Stroot Baltime	MD 24204		
_	ate	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn 3  31 Date filed (Apr. 2007, Apr.) 2007  32 Registrar's Signature	orreer, Baitimore	s, IVID 21201		<del> </del>
Regis		WITH O'U LOUI JOHNSON TO THE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Milton Drumgoole an 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death me (If not institution, give street and number Examiner 8. Date of Birth (Month, Day, Ye 10/06/1923 3irthplac Country) VA If Under 1 Year Sex 14 M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Year) 83 230-12-2937 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 XYes 2 No Director MD Baltimore 5 4 1 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code with 0 316 N. Carrolton Avenue 21223 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinen once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 <sup>Specify:</sup> African American Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) laborer construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Varry Drumgoole Jeannie ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 316 N. Carrolton Avenue; Baltimore, Maryland 21223 Amy Drumgoole / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Mount Zion Cemetery 04/02/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 North Gilmor Street; Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or all a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed the burial-transi and resulting in death) Last Due to (or a Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28b Time of 28a. Date of Injury Injury at Work? 28d. Describe how injury occurred or Attending Fafter death. (Month, Day Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) nner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B BA 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 39 PM FLORIDGE jardon 24 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns HOPKINS Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1□**₩** 2□ F Maryland Jul 7, 1938 Director 68 216-34-8732 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Glen Burnie Director Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 21060 U.S.A 7911 Freetown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or iter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1959 3altimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify Specify. Black δ 3 ☐ Widowed 4 ☐ Divorced 1963 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MTA Elementary/Secondary (0-12) College (1-4or 5+) Transit Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mable Eldridge William Eldridge ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once. 7911 Freetown Road Glen Burnie, Maryland 21060 Elaine Eldridge Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Rurial 2 ■ Cremation 3 ■ Removal from State Crownsville, Md. 03/30/07 4 Donation 5 Dother (Specify) Crownsville Veterans Cemetery 21. Signature of Funeral Service Le 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or he art failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician MINUTES odden disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MINUTES monor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Kidne months the burial-tran Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Livé birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2∏ No 3 Probably 4 ₩Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s 2 No 2 No Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21X No 1 M Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier <mark>٢ Certifying Physician: To</mark> the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

P.O. Box 68760, Division or Vital Records, within 24 hours after death

To the Funeral Director:
completely filled in by the 1 To the Hospital

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH

29b. Signature and title of certifier

State Registrar

Fuentes 600 N. WOHE 31. Date filed (Month, Day, Year)

3 Registrar's Signature

ST. BAUTIMORE MD 21287

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Mildred Elise Everhardt 26 2007 March 12:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing and Rehab. Baltimore Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 13,1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 XF 87 Director 214-14-3102 Maryland Usual Residence of Decedent with the Maryland ehow. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23a or 28a-f ehov the Medical Exeminer must be notified at 1 ☐ Yes 2 A No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 Rambling Drive 21228 USA death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 28 No Specify White Specify: δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 it of Health and Mental Hyg If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Blaine Wolfe ပ Clara Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Everhardt - Daughter 921 Rambling Drive; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 Toremation 3 ☐ Removal from State 03/28/2007 Metro Crematory Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensei 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Venentia Physician 6, mlar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 2 No detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kaymond Miller D47683 and addess of person who completed cause of death (Item 23a) (Type, Print) n Maymond Miller Main Street 200 32. Registrar's Signature 31. Date fired (Month, Day, Year) State MAR 3 0 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #5, perFH, g866, 4/13/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** าชี 2007 2:50 P M March Harriet E. Fenical /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Vantage House If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) Pennsylvania 5. Social Security Number 9079 172-01-9709 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 96 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" ~ "- any injury or other traumatic event." 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5400 Vantage Point Road 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. þ Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Keen George Manderbach ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Franz (Friend) 9249 Spring Valley Road Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 3-24-2007 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Narge and Address of Facility tzke Funeral Homes, 55 Twin KNolls Road INc. Columbia, Maryland 21045 23a. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lattinity one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Aoluence
Due to (or as a consequence of): the burial-tran attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the signed for detached for signed 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perform this certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending investigation 1 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours and control of the Funeral Director; After control of the funeral Director of the fur

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1610

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:15 PM Calvin John Fritsch, March 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford <u> Upper Chesapeake Medical Center</u> Belair If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min 1**X**M 2□ F Hours Director 220-74-2087 47 12/30/1959 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 818 Foxwell Road 21085 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 💢 No 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Repairman Security Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin John Shirley 2 Fritsch, Sr. Ann Groat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Father) Pages 1 and 2 s ment of Health an Health tem 27 818 Foxwell Road Calvin John Fritsch <u>Joppa, Maryland 21085</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3639 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. Most Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Lichard 23a. Part1. Enter the disease, of computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 6 days disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner acctie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-tra Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Dav Year 5 ☐ Other (specify) be detached 1 ☐ Yes 2 ☐ No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 Probably 4 Unknown Acute Rewal Failure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Chronic Lymphocytic page 2 autopsy perform certificate Adult Respicator 2/10 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State Registrar mue

0 2007

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 $\Pi P$ 

2. Registrar's Signature

00053568

500 upper Chesapenka

March 25

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2 Per PHY Good 4/04/07 In Certificate of Death For State Registrar Reg. No. 2. Date of Death Month **28**Day March <del>29</del>, 2007 1. Decedent's Name (First, Middle, Last) **Physician** 9:00 aM Forbes Barbara /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 1716 Dundalk Ave. Baltimore 8. Date of Birth (Month, Day, Year) March 29, 1942 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 X F 64 214-38-5899 West Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Item 27 Is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 1716 Dundalk Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Specify. ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Merritt House II Cook 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be f and Mental I Laura V. Collins Howard H. Shrader 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health an 1716 Dundalk Avenue, Baltimore, Maryland 21222 Husband John C. Forbes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 31 Pages 1 Department of Important: If It any injury or conce. 1 ☐ Burial ZX Cremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 2007 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Uterine Cancer **Physician** years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed?

1 Yes 2 Xo or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Medical Certification: To Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. i Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funeral Dire completely filled in by 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospitai

State

MD

and manner stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

00043934

Name and address of person who completed cause of death (Item 23a) (Type, Print)

PLACE BALTIMORE MD 21202 PAUL  $\langle 1 \rangle$ 224 工川 32. Registrar's Signature

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

MAR 3 0 2007

Registrar

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	Physicia		Frank P	Foctitt	0				М	onth	Day	Year		
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	Funeral Director		5. Social Security Number 6. 220-07-4632	17€] M 2 □ F	e (In yrs. 1 86	ast biπn Yı	Months Days	Hours	Min. (M	ate of Birtl fonth, Day	, Year)	C	thplace (State or For ountry) Vland	eign
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	show show	'n	10a. State 10b. County				or Location						10d. Inside City Lin	
	10 M	Director	Maryland   10e. Street and Number		Bal	timo	10f. Zip Code				10a Citiz	en of What C		
3	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene is filem 21 is marked other then "natural", or Items 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at	ā	1208 Glyndon Ave	•			21223			:	USA		,	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. \_\_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Vincent Maurice Guida Mary 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number Baltimore 8. Date of Birth (Month, Day Year) ot Baltimore If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York Months Days Hours 1⊠M 2□F 102-36-8622 63 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11284 Rider Mark Row 21044 U.S.A. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Guda , Vin cert Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 sho lid be filed within Department of Health and Niental Hygisne-Important: If item 27 is marked other than " any Injury or other traumatic event, the Magnes. College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Guida Rose Vella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 11284 Rider Mark Row Columbia, MD 21044 Rita Guida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, MD 3-24-2007 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Lice Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Du To (or s a consequence of): disease or condition resulting in death) Weseki talluk /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and -tran physician a Box 68760 Physician/Medical as attending property for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death P.0. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed death? 2 □ No Division or Vital 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D0061389 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's/Signature of Bultimore 2901 W. Beliedere Are 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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			Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath		3. Time of Death
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	Funeral Director		5. Social Security Number 213–10–6733	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 99	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day NOV • 29	y, Year)		place (State or Foreign intry) yland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
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Baltimore,	ges 1 t of H if ite or ot		20a. Method of Disposition 1 Surial 2 Cremation	3 □Removal from	n State	Place of Dispo cemetery, crei	natory`or c	ther place	´ 1		Date	20c. Location	on - City or T	own, State
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Vital	sician: The certificate rector, pag	BeC	25. Was case referred to medical						26. Place	e of Deat	n (Check only o			20.10
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 430 **Physician** LoveHq T Gr. ffing
4a. Facility Name (If not institution, give street and number) 24 - 2007 03 /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville 9 Winters Cane Bastimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Director 79 Aug. 10, 1927 Maryland 214-24-0342 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19 Winters Lane Apt. 207 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Siefert ဂ္ Lilly Mae Bartel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: if item 27 is r
any injury or other traur 707 Charing Cross Road; Catonsville, MD 21229 Barbara Corbin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 3-30-2007Baltimore, Maryland 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catons Ville, Inc. 21. Signature of Egneral Service Licensee 1630 Edmondson Avenue: Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Physician minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or s a consequence of): years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) signed by the ald d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by peripheral vascular disease 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2XINo death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Natural 2 Accident ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a

To the Funeral I

completely filled

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Delova 31. Date filed (Month, Day, Year)

MAR 3 0

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

700 Creipe

32 Registrar's Signature

Medical

DHMH 17 Rev 1/2001

Registrar

Ld.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0058206

atonsville, MD

29d. Date signed (Month, Day, Year)

03-26-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 28, Day 2007 Year Mary E. Hammen 5:15 P<sub>M</sub> **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | June | 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yea()916 90 215-09-7717 1 ☐ M 2 🗹 F Yrs. Baltimore, MD Director Usual Residence of Decedent 10b. County Baltimore 10a. State 10c. City, Town or Locatio Parkville 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 No Completed by Funeral Director 10f. Zip Code 21234 10g. Citizen of What Country? 10e. Street and Number ms 23a or ? r must be r 3044 Oak Forest Dr. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.White 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natui any injury or other traumatic event, the Medical i once. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKET At Home Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last)
John Beecher Maryland Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1013 Susquehanna Ave. Bowleys Quarters, MD 21220 19a. Informant's Name/Relationship (Type, Print) John E. Hammen-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cardens Of Faith Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3-31-2007 Rosedale, MD 4 □ Donation / 5 □ Other (Specify) 22. Name and Address Warsy Fineral Chapel & Chemation Services 21. Signature of uneral Servi Parkville 8800 Harford Rd. Parkville, MD 21234 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ENU Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Box 68760. Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Dav 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 2 **2** No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) + HOSPIC 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 □ Yes 2 □ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3-29-01 Timonium, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. TARIP MAHMOOD 2.

State Registrar 31. Date filed (Month, Day, Year)

MAR 3 0 2007

200

3

32. gistrar's Signature

300 Qularay Valley Rd

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 3/23/07 6:30 p.M. Helen K. Huber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Heritage Harbour Health and Rehab. Cntr. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. 5/5/05 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 200 217-34-6162 101 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County 1 Yes 2000 Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e items 23a oner must b 8016 Ritchie Highway Funeral 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian "natural", or items edical Examiner m Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: <u>م</u> 3 XWidowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 Supervisor Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ traumatic <u>Frederick Max Keller</u> <u>Christine Hilda Kuemple</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i B264 Harness Creek Rd., Annapolis, MD 21403
ace of Disposition (Name of Date 20c. Location - City or Town, Julian Easterday/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If It
any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/28/07 Baltimore, MD 21. Signature of Funeral Servide License Mo 1489 Gary L. Kaufman Funeral Home @ MMP, Inc.

7250 Washington Blvd., Elkridge, MD 21075

Washington Blvd., Elkridge, MD 21075

Approximately Compared the Compared to the Cary L. Kaufman Funeral Home @ MMP, Inc. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Exam Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical as attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has e 2 autopsy s certificate has irector, page 2 perform director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **∑**ONo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this After this funeral of 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SW 121 31. Date tiled (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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Please Type o	or Print in Black Indelible Ink. Ensure All Co	pies Are Legible	•	
State	of Maryland / Department of Health and Mental	Hygiene	200	7 1013
r State strar	Certificate of Death	Reg. No.	G 0 0	, , , , , , ,
ecedent's Name (First, Middle,Las	et)	Date of Death     Month Day	Year	3 Time of Death
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		1- For State Certific Registrar	ficate of Death	Red	J. No.	: 0 : 0 :
Physicia		Decedent's Name (First, Middle,Last)		2. Date of Death		3 Time of Death
Medical Exami	ner	Ronald E. Harmon, Jr.  4a. Facility Name (if not institution, give street and number)		March 27, 2	2007	2253 hrs
		Johns Hopkins Hospital	4b. City, Town, or Location of Deat Baltimore	n	4c. County of Death	
Funerai		Social Security Number 6. Sex 7. Age (In yrs. last		s 8 Date of Birth	(MM/DD/YYYY) 9. Birth	polace (State or
Director			Months Days Hours Mir	╗	Foreign	1
		Usual Residence of Decedent	16 Yrs.	03/29/1	990   000	ntry) MD
апу	-	10a. State 10b. County 10c. City, To	own or Location			10d. Inside City Limits
1aryland 28a-f show any 1at once.	<u>_</u>	MD	Baltimore			1 X Yes 2 No
faryla 28a-f	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	ry?
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h with	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? ( S		14. Race - Americ	an Indian, Black,
r deat or ite must	튒	1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	rican, etc.)	White, etc. <b>African</b>	American
s afte	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates;	1 Yes 2 X No specify:		Specify:	
2 hour	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	Sa. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Business/In	dustry
)36 hin 7 than edical	힐	g	atudant		. 1 7	
215-0036 be filed within 72 ntal Hygiene. ked other than "	Ö	17. Father's Name (First, Middle, Last)	student 18.Mother's Name	e (First, Middle, Ma	school	
21215-( uld be filed Mental Hyg marked oth	Be	Ronald E. Harmon, Sr.	Juan	ita Brown		
221 hould nd Med is man	유	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, State,	Zip Code)
ore, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, the Medical Examiner must be notified at once		Juanita Brown / Mother  20a Method of Disposition   20b. Pla	1114 Montford Avenue; Bal	timore, Ma	ryland 21213	
nore, ages lan nt of He t: If ite			ce of Disposition (Name of cemetery, matory or other place)		20c. Location - City or T	own, State
imore Pages   ment of F tant: If i				02/2007	Baltimore, Ma	arvland
Baltimore, permit. Pages I at Department of He Important: If ite		21. Signature of Foneral Service Licensee	22. Name and Address of Facility Wy1	ie Funeral	Home, P.A.	•
		23a- Part I. Enter the assease, or complications that caused the death. Do	638 N. Gilmor Street	: Baltimor	e. Maryland 2	21217 Approximate Interval
Physician /Medical		failure. List only one cause on each line.		or respiratory arres	it, shock, or neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Multiple Gunshot Wounds  Due to (or as a consequence of):	<u> </u>			Death
		Sequentially list conditions, bb.				
	Je.	if any, leading to immediate cause. Enter Underlying Cause				
	Examiner	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			-	
executed an and al - transit		d				
0 15.2	/Medical	UNPENDED AMENDED				
8760, ificate being physicials the buria	§	IF FEMALE. 23c. If yes, outcome of pregnar 23b. Was decedent pregnant in the			23d. Date of delivery	
lox 687 leath certific e attending properties for use as the	sician	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pregnation 5 Other (Specify)	ancy	Month Da	ay Year
Box 68 e death certi the attending ed for use as	ysi	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			
P.O.   s that the gned by the	y Phy	Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
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of Vital Records, ng Physician: The law require the continuation of the continuation o	O B	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ EF	R/Outpatient 3 DOA Other Nursin	ng Home 5 R	esidence 6 Other:	
of Vi ing Physi After this funeral dir	T.:	(Month, Day, Year)	3b. Time of Injury 28c. Injury at Work?	28d. Describe ho Subject was s	w injury occurred	
ivisior or Attend after death Director:	ä	2 Accident Investigation	Tes 2 W No			
Division tal or Attendir ts after death al Director: A	Certification:	Suicide Could not be	e, farm, street, factory, office building, etc.	or Town, Sta	reet and Number or Rura	
Di ospital - hours a uneral f		4 V Homicide			Street, Baltimore, MD	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	Medical	Certifying Physician: To the best of my knowledge, one)  Certifying Physician: To the best of my knowledge, one)  Medical Examiner: On the basis of examination and/				
To To Conf.	Med	and manner stated  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)
		Parent Garthauer nan	O.C.M.E.	1	March 28, 2007	
7		30. Name and address of person who completed cause of death (Item 23	Ba)			
V		Pamela E. Southall, MD Assistant Medical Exami	ner 111 Penn Street, Baltimore, I	MD 21201		
	ate	31. Date filed (Month, Day, Year)  MAR 3 0 2007  33 Registrar's Signature	Searle)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) If Under 1 Year Months Days **Funeral** Months 217-88-0298 1 □ M 2 1 F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County ns 23a or 28a-f show must be notified at 1 DYes 2 No Funeral Director 10g. Citizen of What Country? 10e Street and Number 21215 SWE 90 Avenu 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) er than "natural", or items , the Medical Exa⊓lner mu Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 ₩idowed 4 Divorced Completed by American 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. tousewife SelF 27 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental h In wie P Jeorge Lowns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltmore MD ZVZ15 Pages 1 and 2 s ment of Health an ANNaM. Gr Swego 27 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 ☐Removal from State Garnson Forest VIA April 2, 2007 Owngs Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility Havi for Close Funeral Searte 21. Signature of Funeral Service Licens Belain Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) 63 MEULTUS TI Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-trans Due to (or as a consequence of) Box 68760, pe Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) P.0. the ( 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**No Hospital: 1 🗌 Yes 1 Inpatient After this 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific of death (Item 23a) (Type, Print) 601 WH RAVEN BLUD BALTIMORE MD 21239 State Registrar

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death enni Year **Physician** 5:50 PM NNSON MARCH 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PAND IS LOW 10
Ladar 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
1 4 / 1 9 7 HOSPITA North west BALTIMORE Social Security Number .Sex M M 2□F 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months 215-24-6122 Director 78 08/14/1928 MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f ehow other traumatic event, the Medical Exampler traust be notified at 1 ☐ Yes 2 🙀 No BALTIMORE Director RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8525 WINANDS ROAD 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Armed Forces? 1XIYes 2 □ No US If Yes, Give ARMY Year or Dates:1950-52 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry WARNER TRACTOR Elementary/Secondary (0-12) Colfege (1-4or 5+) TRACTOR-TRAILER DRIVER TRAILER CO. 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mit. Pages 1 and 2 should be fil. partment of Health and Mental Hiportant: If Item 27 is marked oth y injury or other traumatic even Be DENNIS JOHNSON, SR. CLARA DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA JOHNSON / WIFE 8525 WINANDS ROAD, RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department of important: if any injury or once. 4 □ Donation 5 □ Other (Specify) THOMAS CEM. 4/02/07 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEICHTS AVE, BALTIMORE, MD nier to disease, or complications that caus the death. Do not enter the mode of dying, such as cardiac or respiratory arrest r he in failure. List only one cause on each he. Onset and Death iate Cause (Final Melas TATIC CARCINOMA Rena **Physician** /Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed the attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? õ Month Year 4☐ Pregnant at time of death 5 Other (specify) r this certificate has been signed by the a ral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2/2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 1 ☐ Yes 2 No ≥ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending death. 1 ☐Yes 2 ☐ No investigation filled in by the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ced hysician 00024228 MARCH 26,2007 completed cause of death (Item 23a) (Type, Print) COURT ROad RANDALISTOWN, MO 21133 SOERTCH IR, MD 5 31. Date filed (Month, Day, Year) 32/Begistrar's Signature State Registrar MAR 3 0 2007

			1 - For Stete Registrar	State of	Maryland / Depa <i>Cel</i>	artment of H			ene 007	10135
	Physici /Medic		Decedent's Name (First, Midd.		thew Jenkin	ıs		2. Date of Death Month Ma	r 28, 2007 <sup>Year</sup>	3. Time of Death 1:55 a <sub>M</sub>
	Examin		4a. Facility Name (If not institutio	n, give street and numb seph Richey Hos		4b. City, Town, or	Location of Death	more	4c. County of Deat	/A
	Funeral Director		5. Social Security Number 213-26-2716	6. Sex 7. 12X M 2 ☐ F	Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 25,	9. Birti 1930	nplace (State or Foreign Violety) Viaryland
	deeth with the Maryland time 23a or 28a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland	N/A	10c. City, Town or Lo		ltimore			10d. Inside City Limits 1 XYes 2 □ No
	3a or 28a	i Director	10e. Street and Number 1040 East 33rd Street	eet		10f. Zip Code	21218	10	g. Citizen of What Co U.S.	,
15-0036	be filed within 72 hours after deeth with the Marylan ital Hygiene. Id other than "neture!; or itame 23a or 28a-f ehow or other than "neture!; or itame 23a or 28a-f ehow event, the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 X Widowed 4 Divorced	If Yas Giva	□ No 1952	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
7-61212	be filed within 72 hours after ital Hygiene. d other then "neture!, or ite event, the Medical Examine	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	nt's Education st grade completed) College (1-4	(Give	dent's Usual Occup kind of work done of DO NOT use retired Longs	during most of wor	rking 1	6b. Kind of Business/	· ·
land	12 should be filed within n and Mental Hygiene. File marked other then "reumatic event, the Me.	To Be C	17. Father's Name (First, Middle, He	<sup>Last)</sup> nry Jenkins			18. Mother's Nan	ne (First, Middle, M Hele	aiden Sumame) n Willard	
Mary	ges 1 and 2 should to f Health and Mer if item 27 is marke or other treumatic		19a. Informant's Name/Relations Germaine Smith Da					nal Route Number. nore, Marylan	City or Town, State, 2 d 21207	(ip Code)
<b>Ба</b> ітітоге,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 ie any Injury or other treu		20a. Method of Disposition  1 Burial 2 Coremation  4 Donation 5 Other (5	Specify)	Metr	matory or other place of Crematory,	Inc	Date 2 03/29/07	Oc. Location - City or Catonsville,	
ga	permit Depar impor any in		21. Signature of Funeral Service	111.8	Ska		others Fune taw Place B	ral Service, P. altimore, Md 2		
	Physician /Medical Examiner		23a. Part. Enfer the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aDue to (or	as a consequence of):	c + F		c or respiratory arres		Approximate Interval Between Onset and Death
S/on,	certificate be executed nding physicien and use as the buriat-transit	dicai Examine	Exquentially set conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence of):					
O. BOX 6	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours letter death within 24 hours letter death. To the Funeurs later death. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be deteched for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal death 3 ☐ ht at time of death 5 ☐	□Ectopic pregnancy □ Other (specify)		- 00	23d. Date of deli Month	very Day Year
coras, r	quires that n signed b uld be dete	d by Pi	Part II. Other significant conditions of the Property of the P	ons contributing to dea	th but not resulting in the u	,	en in Part I.		acco use contribute to	. /
I Keco	The law rec ete has bee page 2 shou	Complete	Penerettic Ca	incer .				24a. Was an autopsy perform	ed?// death?	topsy findings available completion of cause of
or vital	hysician: his certific i director,	To Be (	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Ing	eatient 2 ER/Outpatier	nt 3□ DOA Oth		ith <i>(Check only one</i> lome 5 ☐ Resider	nce 6 Mother (Spec	Mospice
DIVISION	r Attending P er death. rector: After t by the funera	Certification;	27. Manner of Death 1 Natural 5 Pendii 2 Accident 3 Suicide 6 Could 4 Homicide determ	igation	Injury Day Year) 28b. Time o Injury  I Injury - At home, farm, str., etc. (Specify)	M 1	yat ⟨? Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Ru	ral Route Number,
ב	Hospitet o 24 hours ett Funerei Di itely filled ir	edicai Cer	29a. Certifier 1 1 Certifyin (Check only one)	ng Physician: To the b	est of my knowledge, deatlis of examination and/or in	h occurred at the tin	ne, date and place pinion, death occu	, and due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within to the comple	Med	29b. Signature and title of certific		MO	29c. License	o number	29	d. Date signed (Monti	n, Day, Year)
	V		30. Name and address of person	who completed cause	of death (Item 23a) (Type.	man My	41210.	1307		
	Sta Registr		31. Date filed (Month, Day, Year, MAR 3 0	2007 Jan	pistrans bignature	will .				

1:55 AM 3/28/07

			For State Registrar	State of Marylar		artment of H			2111	17	10136
			Registrar  1. Decedent's Name (First, Middle, Last	)	Cei	lineale or L	Jean	2. Date of Death	g. No.C. U		3. Time of Death
	Physicia	_	JAMES	JACKSON	/			Month 03		ear	7: 30 A M
, i	Medic /Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of	Death	
	LAGIIIII	-	Liberty Heights	s Nursing H	ome	Baltimo	re		N/A		
37	Funeral		5. Social Securify Number 6. Se		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign stry)
	Director		223-05-0806	95	Yrs.			1/10/19	)12 \	7ir	ginia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho ied at	ē	Md N/A	R	altimo	nre					<b>X</b> □Yes 2□No
	1 the	Director	10e. Street and Number		ar orm	10f. Zip Code		10	g. Citizen of Wh	at Coun	itry?
	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show snt, the Medical Examiner must be notified at		4017 Liberty He	eights Aven	ue	21207	7	τ	JSA		
	ems :	Funeral	11. Marital Status	12 Was Decedent Ever in I		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	Americ White,	
98	after, or it	by Fu	1 ☐ Never Married 2 ☐ Married  > Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes XXNo If Yes, Give	1	1 □ Yes 2 X No	Specify:		Specify:	21 0 0	a le
21215-0036	hours tural' al Ex	g p	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occup	ation		6b. Kind of Busi		
5	in 72 n "na Medic	plet	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	during most of work f)	ing			
212	r tha	Completed	Elementary/Secondary (0-12)	College (1-40r 5+)	School	ol Bus D	river	₽r	rivate	Con	npany
	al Hyger of the location of th	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Surname,	)	
ylaı	Ment Ment arked atic e	으	Major Clark				Gladys_		,		
Maryland	2 sho n and ls m raum		19a. Informant's Name/Relationship (7)	vpe. Print)		ng Address (Street			-		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	- 2	Evelyn Howard  20a, Method of Disposition	20b.	Place of Dispo	Peridot  position (Name of matory or other place	Drive,		a Beac		7a.23456
Baltimore,	ages nt of t: If It		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State						•	
Ţ.	nit. P. artme ortani Injury		4 □ Donation 5 □ Other (Specify) 21. Signs up of Funeral Service Licens		2:	n Cemete	ss of Facility				ıa.
Ba	permi Depar Impo any Ir once		Vaud V	1850	Es	step Bro 300 Euta	thers F	uneral	Home, H	Α.,	21217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		MI						Onset and Death
a	/Medical		resulting in death)	Due to (or as a conse	quence of):	41					
В	Examiner		Sequentially list conditions,	b. Caraco	uso pa	ely				2	
١.	ed sit	nine	cause. Enter Underlying	Due to (or as a conse	uence pr):						
3	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	quence of):						
Box 68760,	e be e siciar sburi	ical		d							
9	tificat ig phy as the	ledi						-			
XO	th cer endin r use	N/ue	23b. was decedent pregnant	23c. If yes, outcome pf pregr 1□Live birth 2□Fe		□Ectopic pregnancy	/		23d. Date		,
	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of 9☐Unknown		Other (specify)	<u></u>		MOII	un	Day Year
P.O.	d by t	Phy	9 ☐ Unknown  Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	ınderlyina cause aiv	en in Part I.	23e. Did tob	acco use contrit	oute to t	he cause of death?
ds,	signe d be c	l by	CHE					1	s 2□No 3	3 ☐ Prot	bably 4 Unknown
Records,	v requ	Completed by	Chame Kilus	ry diseas	0 ,			24a. Was ar	24h W	ere auto	opsy findings available
Rec	e la has	mpl	Curone Ferr	Caeso				autops: perform	y pr ned? de	ior to co ath?	impletion of cause of
ta	ician: Th certificate ector, pag		25. Was case referred to medical			-	26. Place of Deat	1 Yes 2		Yes	2 □ No
or Vital	Physician: this certific	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing Ho	ome 5 Reside	nce 6 □Othe	r (Speci	fy)
0	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurre	d	
Sio	Attending r death. ector: After by the funer	atic	2 Accident investigation				Yes 2 □ No				
Division	or Att fter de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (Sti City or Town	reet and Numbe , State)	r or Run	al Route Number,
	Hospital or 44 hours afte Funeral Dir tely filled in		29a, Certifier 1 Certifying Ph	ysician: To the best of my ki	nowledge, dea	th occurred at the fi	me, date and place	and due to the ca	ause(s) and man	iner as s	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director. completely filled in by the	Medical		iner: On the basis of examinand manner stated.							
	To the I within 24 To the I complet	Me	29b. Signature and title of certifier			29c. Licens	e number		9d. Date signed		
			My Zual	MD		D3	9127		3/26/	20	07
	ہر		30. Name and address of person who of A A HMED MD 82	completed cause of death (lite in the completed cause of death (lite in the complete in the co	em 23a) (Type,	Print)	- MD	2120	1		
4	Sta	ate	31. Date filed (Month, Day, Year)	32. gistrar's Sig	nature	hade					
Ä.	Regist	rar	MAR 3 0 2	007 Server	15. 19						

		For State Registrar	State of Ma	-	oartmen e <i>rtificat</i>				ental Hy	giene Reg. No	4001	0	137
Phys	sician	Decedent's Name (First, Middle, L.	ast)						2. Date of De Month	aath Da	ıy Yea		of Death
/Me	edical	Anna Dor		elly	4h Ciby	Town or	Location of		March		2007 : County of De		:45 <sup>P</sup>
Exa	miner	St. Joseph Medica			Tow		Location	o. Dog			Balti		
Fune		5. Social Security Number 6.		(In yrs. last birthda			If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	av. Year.	9. 8	Sirthplace (Stat Country)	te or Foreign
Direct	tor	212 14 9216 Usual Residence of Decedent	- X	86 Yrs.				1	Nov. 9	,192	0 Ma	ryland	
yland		10a. State 10b. County		10c. City, Town or	Location								City Limits
Ba-f s	Director	Maryland Baltimor	re	Esse									es 2 No
with the a or 2	Dire	10e. Street and Number 30 Seaford Aver	1110		10f. Zip		1221			10g. Ci	tizen of What	Country? SA	
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-f show the Maryland energing the propriet of the Maryland.	Funerai	11. Marital Status	12 Was Decedent E	ver in U.S. 13	. Was Deced			igin? (Spec	ofy Yes or Notican, etc.)	)-	14. Race - Ar	nencan Indian	,
36 after or its	Fu	1 Never Married 2 Married	Armed Forces?  1  Yes 2 X No. If Yes, Give	0	1 ☐ Yes		n, Mexicar Specify:		Rcan, etc.)		Specify: + +		
hours tural,	od be	3X Widowed 4 Divorced	Year or Dates:	16a Dec	edent's Usua					16b k	Specify: W		
215- 215- 215- 215- 215- 215- 215- 215-	Completed	(Specify only highest g.	rade completed)  College (1-4or 5-	(Gir	re kind of wo . DO NOT us	rk done r	durina mos	t of workin	g	100. 1	Kind of Busines	ss/maustry	
212 ad with /giene er tha	Som	Elementary/Secondary (0-12)	College (1-401 54	Hom	emaker						Own Ho	me	
and 2 d be filed antal Hygi cetother	Be	17. Father's Name (First, Middle, Las	owski				18. Mothe	_	(First, Middle nanna		sumame) Siarko		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene, Important: If tenz 27 is marked other than "natural; or itema 23e or 28e-f show any injury or other traumatic event; the Medical Examination and indicate notified at	To	19a. Informant's Name/Relationship Bert Kelly (so			iling Address Basin				Route Numb		or Town, State	, Zip Code)	
re, ls 1 an (Heal)	L	20a. Method of Disposition		20b. Place of Dis		ne of	Ī		ite	_		or Town, State	
Itimore, iit. Pages 1 ar intment of Hea intent: If Itam:		1 🗗 Burial 2 □ Cremation 3 ( 4 🌓 Conation 5 □ Other (Spec		Holly Hi	,		1	3/30	0/2007	Bal	timore	County	, Md.
Balt permit. Departr Imports	DCG.	21. Signature of Funeral Service Lice	angee -	X	22. Name an			DI				l Home	
	u u	23a. Part1. Ther the disease, or constock or heart failure. List on	olications that packed to								Maryla	Approxin	
Physicia	an	Immediate Cause (Final									01 =	Interval E Onset ar	Between
/Medic	al	disease or condition resulting of death)	Due to (or as a	consequence of):			17	EHK	7 01	26	ASE	140	news
Examin		Sequentially list conditions, if any, leading to immediate		OLONYO consequence of):	PATI	14						Non	etro
Doi:	Examiner	cause. Enter Underlying Cause (Disease or injury	RENA	. ,	SUF	FIC	150	1100				da	11
60, % be executed sicien and burial-transit			Due to (or as a	consequence of):	<u> </u>		100	009					/
8760, sate be exphysicien githe burial	음		La SEPSI	5								100	4
BOX 6 leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of	f pregnancy							23d. Date of c	folion.	
. 0 00	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□Ectopic pr □ Other (sp						Month	Day	Year
hat if	Phy		contributing to death but	t not resulting in the	underlying c	ause give	en in Part I.		23e. Did 1	obacco	use contribute	to the cause of	of death?
	od by								1 🗆	Yes 2	!□No 3□	Probably 4	Unknown
O 3 TO S									24a. Was		24b. Were	autopsy finding	gs available
I Rec The law ate has b	Con					,			auto perfe	psy ormed? 2□/No	death	o completion o ? es 2□ No	of cause of
Of Vital Re Physician: The la rithis certificate has	Be	25. Was case referred to medical examiner?	. Upperite la			1 04		of Death	Check only				
Of O Physical This canding	2		Hospital: 1 Inpatien 28a. Date of Injury		ent 3 DC	8c. Injury	4 🗆 140		e 5 Resi		6 Other (S	pecify)	
ion of noting fath.: After e funer	ation	1 Natural 5 Pending 2 Accident investigate	(Month, Day	Year) Injury		Work	`<br Yes 2 □		30. 5000.150		ny ocounica		
DIVISION OF I or Attending Phy after death. Director: After this	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		ry - At home, farm, (Specify)	street, factory	, office		21	8f. Location ( City or To	Street a wn, State	nd Number or e)	Rural Route N	umber,
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the tuneral director;	edical Co	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	examination and/or	ath occurred investigation	at the tim	ne, date an pinion, dea	nd place, ar oth occurre	nd due to the d at the time,	cause(s date an	i) and manner d place, and d	as stated. ue to the cause	e(s)
o the vithin 2 o the	Med	29b. Signature and title of certifier	and manner stat		290	. License	number			29d. Da	ite signed (Mo	nth, Dey, Year	•)
P ≤ P Ö		> Sne	pheno		1	00	) 5 3	150		MA	R(11	290	2007
3.0		30. Name and address of person who		ath (Item 23a) (Typ	e, Print)					1 . 13	50	INE	(0)
	0	5 h ALWN M	ACA GU	's Singature	46SC	5	AN	TIA	60	U	ADM	29 9 11 ME 1 CO( UI	n BH
18 7 W	State	31. Date filed (Month, Day Year)	107 Masure	JJ. KI	Contract of the second								- 73

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 26 2007 **Physician** march Hwa-Young Kim /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balt more Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) **Funeral** Days 1**X** M 2□ F Hours 66 9/25/40 530-98-4166 Seoul Korea Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2X No Director MD Howard Elkridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21075 Funeral 6498 Sawgrass Court Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 200 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: Asian Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Self Employed Wholesale Import/Export 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Heung Gin Kim ٩ Kyu Dong Kim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 is other tra 7430 Jeans Way, Fllicott City, MD 21043 Lice of Disposition (Name of Date 20c. Location - City or Town, State <u> Elaine Hee-Jung Kim/Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 3/29/07 Elkridge, MD 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ MMP, Inc. 21. Signature of Funeral Service Licer 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 I Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 3 ☐ Probably 4 ☐ Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2□ No 1 ☐ Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA P this in by the funeral 27. Manner of Death 1 Natural 28b. Time of Medical Certification: 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

MAR 3 0

John Ave Baltimore bozeno KOCZHON

**#**gistrar's Sigпature 32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		
State of Maryland / Department of Health and Mental Hygiene	200	7
Contificate of Dooth		0

		_5	- For State Registrar		Cert	ificate of l	Death			eg. No.		
Physional Example 1		n/ er	1. Decedent's Name (First, Middl Phyllis	I. Kra	snodems				2. Date of Deat Month March 28,	Day Year 2007	1300 hrs	
)		ľ	4a. Facility Name (if not institutio 6506 Hartwait Street	n, give street and no	umber)		. City, Town, or Lo Baltimore	ocation of Death		4c. County of	f Death	
Funera Directo			5. Social Security Number 212 - 58 - 2001	6. Sex	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1		9. Birthplace (State or Foreign Country) Marylan	
any			Usual Residence of Decedent  10a. State 10b. County			own or Location	1				10d. Inside City Limits	
laryland 8a-f show	at once.	<u>.</u>	Md.		Ва	altimo:	C E		14	0g. Citizen of Wha	1 X Yes 2 No	
h the Mar 13a or 28a	tified .	ě	6506 Hartwai				2122			US	A	
6, MD 21215-0036 I and 2 should be filted within 72 hours after death with the Maryland Health and Mental Hygiene.	-			arried Armed F  1 Yes orced If Yes, Give Ye or Dates:	2 X No ar	If Yes	Decedent of Hispa , specify Cuban, I res 2 No	Mexican, Puerto I		- 14. Race - White, Specify:	- American Indian, Black, etc.  White	
136 thin 72 hours te. than "natur	Exan	Completed	15. Decedent's Education (Special Elementary/Secondary (0-12) 9 t h	cify only highest gra	de completed) 1-4 or 5+)	during mos	Usual Occupation to of working life. If	OO NOT use retire		16b. Kind of Bus	iness/Industry Home	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		Re	17. Father's Name (First, Middle, William Wayl	bright				3.Mother's Name Va Roh		Maiden Surname)		
MD 21 d 2 should lith and Me n 27 is man			19a. Informant's Name/Relations Lois Eaton (s			7958 1	Kavanag	h Rd.	Baltin	•	d. 21222	
imor Pages ment of tant: If	or other traumatic		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Sa	pecify:	rom State   Cr	ematory or other dens	of Fait	h 3-3		Baltime	City or Town, State Ore,Maryland	
Balt permit Depart Impor	injury		21. Signature of Funeral Service	Licensee							eral Nome,PA , Md. 21222	
Physicia /Medica	al		failure. List only one cause	a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  mediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease								
Examine	er		or condition resulting in death)		a consequence of)		Vaccara, Broo					
	ı.		Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause		a consequence of)	:					23	
executed an and		Ĕ	(Disease or injury that initiated events resulting in death) Last		a consequence of)	:				-		
- 43 '53 '	burial - 1	n/Medical	UNPENDED	AMENDED						Taxa : :		
	r use as the	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregna birth nant at time of dea	2 Feta	I death 3	Ectopic pregnal	псу	23d. Date of o	Day Year	
D. Bo	ched	≥L	1 Yes 2 No 9 V Uni	9 Uliki	nown to death but not re	sulting in the un	derlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?	
S, P.O uires that t	det .	ed by	Seizure disorder			<del></del>					Probably 4 Unknown	
, F & F	age 2 should	ompleted								sy pr	/ere autopsy findings available rior to completion of cause of eath?  Yes 2 No	
tal Rec cian: The certificate	2 0	ပေါ-	25. Was case referred to medica					of Death (Check o	only one)			
Vit.		인	examiner? 1 ✓ Yes 2 No	Hospital: 1		ER/Outpatient				Residence 6		
ion of tending Pl eath orr: After	the funeral	tion:	27. Manner of Death  1  Natural 5 Pend 2 Accident Inve		e of Injury th, Day,Year)	28b Time of Inj		at Work?	28d Describe	how injury occurre	ed	
Division  e Hospital or Attendi 124 hours after death e Funeral Director:	filled in by the	ertification	3 Suicide 6 Cou		ce of Injury - At ho	me, farm, street	factory, office bu	ilding, etc.	28f. Location ( or Town, S		er or Rural Route Number, City	
DIV To the Hospital or within 24 hours afte To the Funeral Dir	completely fi	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the beaminer: On the basis	of examination an	e, death occurre d/or investigation	ed at the time, date on, in my opinion,	e and place, and death occurred a	due to the caus t the time, date	se(s) and manner and place, and du	as stated. ue to the cause(s)	
<b>)</b>	00	₩	29b. Signature and title of certific		u D		29c. License O.C.N			29d. Date signe	Month, Day, Year)	
N		}	30. Name and address of persor Melissa Brassell, MD	•	,		enn Street, Ba	altimore. MD	21201	J		
	- 1		31. Date filed (Month, Day Year)	-	strar's Signatur							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Month Day **Physician** 930AM clanne 28 2007 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5 for the vice st HOSPIT al Randa wn Ba 7 imort If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🙀 F Min Director 409-34-1278 81 02/15/1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No Examiner must be notified MD Director BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with or Items 23a 14. Race - American Indian, 12 REDLEAF ROSE COURT 21136 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE If Yes, Give ... Year or Dates Specify 3 ☐ Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: if item 27 is marked other than any Injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER SOCIAL WORK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARVIN RICHARDSON SR. ANNIE YARBOROUGH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REDLEAF ROSE COURT - RESITERSTOWN, MD 21136 BEN LEVEY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 03/29/2007 5 ☐ Other (Specify Donation TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Tuneral Se INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 art1. Enter the disametric shock, or heart failure. , or complexitions that of sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years hronic /Medical Due to (or as a consequence of) Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar requires that the death certificate be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate ! 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No ို 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation Injury 1 Natural thin 24 hours after the control of the Funeral Director: After the funeral by the funeral properties of the funeral fu 1 ☐ Yes 2 ☐ No 2☐ Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur# and title of certifier 29d. Date signed (Month, Day, Year) 28 200+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 a nrist INE 31. Date filed (Month, Day, Year) Registrar's Signature 32 State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

			For State Registrar	te of Marylar		artment of F			giene 007	0 4
	Physici /Medio		1. Decedent's Name (First, Middle, Last)		MA			2. Date of Dea Month MARCH	27 2007	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, give street a		HER	4b. City, Town, o	r Location of De	ath	4c. County of Death	1
	Funeral Director		5. Social Security Number 498-52-3279 153M 2	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours Mi			nplace (State or Foreign untry) MO
	and the transfer of the transf		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	a-f sho	ctor	MO Saint Lou	is		Ches	terfie	1d		1 XYes 2 □ No
	with the	Funeral Director	10e. Street and Number 1831 York Ridge	Court		10f. Zip Code	3017		10g. Citizen of What Co USA	untry?
	death	neral	11. Marital Status 12. Wa	s Decedent Ever in U	J.S. 13.			(Specify Yes or No- erto Rican, etc.)		
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show fra Medical Evantirer must be notified at	by Fu	1 Never Married 2 Married	Yes 21965-1965-196 es, Give 1965-196 er or Dates:	67	1 ☐ Yes 2000	Specify:	ento mican, etc.)		1ack
2-00	72 hou natura ilcal E	eted	15. Decedent's Education (Specify only highest grade comp			dent's Usual Occup		vorkina	16b. Kind of Business/	ndustry
121	within lene. than "	Completed		ege (1-4or 5+)	life.	DO NOT use retired Parts Ass	d)	9	Automoti	ve
Maryland 21215-0036	oe filed al Hygid d other svant, I	Be	17. Father's Name (First, Middle, Last)					lame (First, Middle,	Maiden Sumame)	
ryla	2 should be n and Mental fa marked o raumatic ave	은	Eddie Malcolm Mar:  19a. Informant's Name/Relationship (Type, Prin		19h Maili	na Address (Street		thy Lee	Johnson r, City or Town, State, Z	in Codel
	l and 2 s lealth an im 27 ta i her traus		Eddie Marx / Brot			1 York		Court,	Chesterfi	eld <sub>63</sub> MO <sub>7</sub>
altimore,	of the state of th		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 XRemova  4 □ Donation 5 □ Other (Specify)		cemetery, crei	esition (Name of matory or other place onal cem	etery	Date	20c. Location - City or Saint Lou	Town, State
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	on Shall		Name and Addres Charles L 501 East	ss of Facility • Steven Fort Av	ns Funera venue, Ba	l Home Inc. ltimore, MI	21230
L			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the deat e on each line.			ng, such as card	iac or respiratory arr		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Congest	TVe	HEART	FAIL	ire		
	Examiner	L		KidNe	Y FA	Lyre		and the second		
4	uted d ansit	Examiner	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury that initiated events	CORONA  ue to (or as a consequence)	. ,	ART ERY	17:50	ase		
8760,7	ate be executed hysicien and the burial-transit	al Exa	resulting in death) Last	ue to (or as a conseq	quence of):	1				
9	# % B	ledical	d	——————————————————————————————————————						
Box	death certifica e attending ph ed for use as th	Physician/Me	in the past 12 months?	es, outcome of pregna Live birth 2 Peta	aldéath 3[	Ectopic pregnancy	,		23d. Date of deli	very Day Year
o.	0 0 0	hysic	1 Ves 2 No 4	Pregnant at time of o Unknown	death 5	Other (specify) _				
ds, P	as the gned se de	by	Part II. Other significant conditions contributin	g to death but not res	sulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to es 2 □ No 3 □ Pro	the cause of death?
Vital Record	> Q 73	Completed						24a. Was a		topsy findings available ompletion of cause of
E E	ician: The lav certificate has ector, page 2 (							perfor 1 🗆 Yes	med? death? 2 <b>≰</b> No 1 Yes	2 🗆 No
		To Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospital	1∰Inpatient 2□	ER/Outpatier	nt 3□ DOA Cth	or:	eath (Check only or Home 5 Resid	ne) ence 6 □Other (Spec	ifv)
	Ntending Phys death. ctor: After this y the funeral dii		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at		ow injury occurred	.,,
Division	ira n b	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At he building, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospital of within 24 hours at To tha Funaral D completely filled i	edical (	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and	the basis of examina	ation and/or in	vestigation, in my o	pinion, death oc	curred at the time, o	late and place, and due	to the cause(s)
	To the within 2 To tha complet	M	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (Month	, Day, Year)
			30. Name and address of person who complete	Cause of death (Item	n 23a) (Type	AU41	76435	B17536 h	1ARch 27	2007
	10		ERICA SCA	VARTZ.	ms)	10 NORTI	h GREER	ic Street	BALTIMER	MD21201
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2007	32. Signa 32. Signa	B. A	parti			19d. Date signed (Month  1 ARCh 27  BALTIMEE	

			1 - State of Marylar State of Marylar		artment of Hea			ene g. No.	7 10142			
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day	3. Time of Death Year			
	/Medic		Marlene Mack				arch	28 20	07 7:00 A™			
2	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo			4c. County o				
			12645 Whisper Trace Dr.  5. Social Security Number 6. Sex 7. Age (In yrs.)	last birthday)	Ocean Cit		. Date of Birth	Worce				
	Funeral Director		217-40-0177 1 M 201 62	Yrs.		Hours Min.	June 5,	1944	9. Birthplace (State or Foreign Country) Maryland			
	P .		Usual Residence of Decedent				, , , ,					
	72 hours after death with the Maryland Instural, or Iteme 23s or 28s-f ehow dical Examiner, ust be myllfau at	'n		y, Town or Lo an City					10d. Inside City Limits 1 ☐ Yes 2X No			
	the M	ectc	10e. Street and Number					- 0'1' 411				
	with a or	Ö	12645 Whisper Trace Dr.		10f. Zip Code 21842			g. Citizen of Wh USA	nat Country?			
	Seath me 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U	.S. 13. V		anic Origin? (Speci	fv Yes or No-	<del></del>	- American Indian.			
က	or iter		Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No	1	Vas Decedent of Hispa f Yes, specify Cuban, M		can, etc.)	Black	Black, White, etc.			
) 0 3	rai', o	b	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 21 No S	Specify:		Specify:	White			
21215-0036	72 h	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	lent's Usual Occupation kind of work done during OO NOT use retired)	in ing most of working	1	6b. Kind of Bus	iness/Industry			
12	within ane. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		oo not use retired) Leader		M	lcCormic	k & Co.			
9	filed Hygie ther	ပိ	12 17. Father's Name (First, Middle, Last)	ai our		B. Mother's Name (	First, Middle, M	aiden Sumame	)			
ylan	Mental Mental arkad c	To Be	Kenneth McDonough			Margaret	(Unkno	wn)				
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Importent: if item 27 is marked other then. natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Externing must be notified any once.		19a. Informant's Name/Relationship (Type, Print)  Mr. Charles Mack / Husband		g Address <i>(Street and</i> 545 Whisper				tate, Zip Code) , MD 21842			
Je,	of Hee itam othe		20a. Method of Disposition 20b. F		sition (Name of natory or other place)	Dat			ity or Town, State			
Ē	Page nent c nnt: if ury or				norial Garden	ns 4/02/2	007 B	altimor	e, MD			
Baltimore,	permit. Depertrimporte		21. Signature of Funeral Service Licensee Kimberly David	ISON	Name and Address o			5 Harfo timore,	ord Rd. MD 21214			
	Physician	3 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
			Immediate Cause (Final disease or condition		Onset and Death							
	/Medical Examiner		resulting in death)  Due to (or as a consequence)	uence of):								
		Examiner	Sequentially list conditions, b. Que to for as a consequence.									
	nsil		cause. Enter Underlying Cause (Disease or injury									
Ć	cate be executed bhysicien and the burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a conseq	uence of):								
8760,	ysicie	cai	d									
9	ng ph	Med	JE ECAMA C.		-							
Вох	th ce tendii	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta				of delivery					
P.O.	thet the death certific ed by the ettending p detached for use as	Physician/Medicai	1 Yes 2 No 9 Unknown 9 Unknown			Mont	Month Day Year					
۵	thet the ed by detact		Part II. Other significant conditions contributing to death but not res	ulting in the ur	iderlying cause given in	n Part I.	23e. Did toba	cco use contrib	oute to the cause of death?			
Division of Vital Records,	The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	ed by					1 🗆 Yes	2 □ No 3	Probably 4 □Unknown			
ဝ္ဂ	aw rea	Completed				24a. Was an	a. Was an 24b. Were autopsy fin					
~	The lay	mo					autopsy perform 1 Yes 2	ere autopsy findings available or to completion of cause of ath?  Yes 2 2 No				
ita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		26	S. Place of Death			s ros Eggino			
<u>&gt;</u>	Physic this ce al dire	2	- Hospital	ER/Outpatien	3□ DOA Other:	4 ☐ Nursing Home	5 Resider	ce 6 □Other	(Specify)			
Ē	ing P		27. Manner of Death 1	28b. Time of Injury	28c. Injury at Work? 28d. Describe ho			w injury occurred				
<u>s</u>	deeth deeth ctor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes	Location (Street and Number or Rural Pouts Number							
<u>≥</u>	를 들는 를	Certification:	determined 28e. Place of Injury - At he building, etc. (Specification)	8f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospitel or At within 24 hours effect To the Funeral Diract completely filled in by	edicai	29a Certifier (Check only one)  12 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the dauce(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To t To tl	ž	29b. Signature and title of certifier		29c. License nu	ımber	29	d. Date signed (	(Month, Day, Year)			
1	1	1	( Jether Matrie no		HOOK	3714		3/28/	10.7			
6	0		30. Name an a fre is the sort who completed cause of death (Item		Print)	Sufe 3	2 0					
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture &		July 2	12 13KK	الارا الال	17 61811			
	Registr		MAR 3 0 2007 Sente A	ture								

			For State Registrar	State of Ma	aryiana / Dep <i>Ce</i>	ertificate of			ene eg. No. 200	7 10143		
r	Physici	an	Decedent's Name (First, Middle, Last)  Edith M. Meads						2. Date of Death Month Day Year			
1	/Medic		4a. Facility Name (If not institution,		ui w. wea		or Location of Death	· ·	Mar 23, 2007 4c. County of De	7:20 р м		
*	LAdiiii	CI		Stella Maris				onium	E	altimore		
	Funeral Director		220-20-2078	5. Sex 7. Age 1	e (In yrs. last birthday 78 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 5	Year) 9. B	rthplace (State or Foreign Country) <b>Maryland</b>		
	nand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
	e Mary a-f sh tified	ctor	Maryland	N/A			Baltimore			1 ☐¥es 2 ☐ No		
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 6822 Collinsdale Ro	ad		10f. Zip Code	21234	10	0g. Citizen of What C	country? .S.A.		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after dea to the health and Montal Hygene. If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu	by	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Wgidowed 4 □ Divorced	12. Was Decedent B Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	<b>t</b> o	1 □ Yes 2 □ <b>1X</b> 0		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:			
5-0	n 72 h "natu edical	etec	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)					ing	s/Industry			
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		usekeeper	Morgan State Universi				
d 2	e filed al Hygie other vent, th	Be Co	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	ame (First, Middle, Maiden Surname)				
ylar	2 should be and Mental is marked raumatic ev	To E	Ed	ward Martin					lary Martin			
Jan	n and n and ris ma		19a. Informant's Name/Relationsh		19b. Mai	19b. Mailing Address (Street and Number or Rura 6822 Collinsdale Road Balt				Zip Code)		
	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other t		James L. Meads Sc  20a. Method of Disposition  1 Kurial 2 Cremation		20b. Place of Disp	osition (Name of ematory or other pla		Date	20c. Location - City o			
Baltimore,			4 □ Donation 5 □ Other (Sp 21. Si) the of Funeral Service L		A.	Forest Vetera 22. Name and Addre	ess of Facility	03/30/07		s Mills, Md.		
	<u> </u>		Tugend	n. Mals			Brothers Func Eutaw Place F			Approximate		
	eath certificate be executed  Attending physician and for use as the burial-transit	i	23a. Part1. En er the disease, or o shock, or heart failure. List of Immediate as se (Final disease or or dition resulting in death)	_a. PANCRE	a consequence of):		ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to or as	a consequence of):							
٠حگر		d by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с			1818					
68760,			resulting in deathy Last	d.	Due to (or as a consequence of):							
			IF FEMALE:	23c. If yes, outcome	nf pregnancy				201 5 1 11			
P.O. Box	requires that the death cer een signed by the attendir rould be detached for use		23b. Was decedent pregnant in the past 12 months?  1						23d. Date of delivery  Month Day			
ds, P.	w requires that the d been signed by the should be detached		Part II. Other significant condition	ns contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.			to the cause of death? Probably 4 (Unknown		
Reco	e law has b je 2 st	Completed	-					24a. Was ar autops perform	y prior to ned? death?	autopsy findings available completion of cause of		
ta	i <b>cian:</b> Th certificate ector, pag	Be Co	25. Was case referred to medical				26. Place of Deat			s 2 No		
>	is dir	To B	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatio		4 ☐ Nursing Ho	me 5 ☐ Reside	ence 6 Other (Sp	ecity) HOSPICE		
o uc	To the Hospital or Attending Ph within 24 hours after death To the Funeral Director. After th completely filled in by the funeral		27. Manner of Death  1 Natural 5 ☐ Pending	(Month, Day	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?			28d. Describe how injury occurred				
Division or Vital Records,		Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 280 Place of inju	ury - At home, farm, s c. (Specify)	M 1 ☐ Yes 2 ☐ No  ne, farm, street, factory, office  28f. Location (Street and Number or Rural Rou City or Town, State)						
	Hospital 24 hours a Funeral stely filled	Medical Ce	29a. Certifier 12 Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner sta		ath occurred at the ti investigation, in my	ime, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)		
	To the within To the	Me	29b. Signature and title of certifier	se number	25	nth, Day, Year)						
			1	-		10	13721		3/24/07			
_	5		30. Name and address of person v	4 MADA 2	300 Dulay		1 RQ. TIV	nonum,	md 2100	3		
ı	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 0 2	82. Registra	ar's Signature	القا						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-	1 - For State Registrar	0.0.0	f Marylan		rtificate			-	Reg. No.	200"	7 101	7
	Decedent's Name (First, Mid	idle, Last)						2. Date of De	ath	<u> </u>	3. Time of De	ath
an cal		G	ladys C	. Myei	'S			Month	Aar 25,	, <b>2007</b> Year	5:50 a	N
er	4a. Facility Name (If not institut	tion, give street and nu	mber)		4b. City, Tov	vn, or Locati	ion of Death		4c. (	County of Dea		
. 4		rankford Nursir					Baltin				N/A	
	5. Social Security Number <b>218-58-2966</b>	6. Sex 1 □ M 2 <b>x</b> □ F	7. Age (In yrs. 54	Vrc	If Under 1 Y Months D	ear If Un ays Hou	nder 24 Hrs. Irs Min.	8. Date of Bir (Month, Da Jan 3	th ly, Year) 1, 1953	C	rthplace (State or F country) <b>Maryland</b>	oreig
'n	Usual Residence of Decedent  10a. State  10b. Coun  Maryland	nty N/A	10c. City	0c. City, Town or Location  Baltimore						10d. Inside Ci 1 <u>M</u> Yes		
Director	10e. Street and Number		10f. Zip Co	de		10g. Citizen of What Country?						
	833 West Pratt Str				1201	U.S.A.						
Funeral	11. Marital Status	edent Ever in U. prces?	U.S. 13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican			c Origin? (Sp xican, Puerto	Origin? (Specity Yes or No- can, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.		
þ	1 ☑ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce	2 No ive Dates:	1 ∐ Yes 2L <b>X</b> No <i>Specify:</i>						Specify:	Black		
etec	15. Deced (Specify only high		(Give	dent's Usual O kind of work of DO NOT use n	one during	most of work	16b. Kind of Business/Industry			s/Industry		
Completed	Elementary/Secondary (0-12	1-4or 5+)	life.	Aide		Baltimore City School System			em			
Be	17. Father's Name (First, Midd.	-		18. M	lother's Name	e (First, Middle, Maiden Surname)  Nancy A. Myers						
2	19a. Informant's Name/Relatio	Aubrey Myers onship (Type, Print)		19b. Mail	na Address (S	treet and Nu	umber or Rur	al Route Numb	er, City or	Town, State,	Zip Code)	
	Anna Owens Siste			1	_			l Baltimore				
	20a. Method of Disposition		1 0	Place of Disp	osition (Name o	of er place)	1 1	Date	20c. Loc	cation - City o	r Town, State	
	1 X Burial 2 ☐ Crematio 4 ☐ Donatio 5 ☐ Other		State		. Zion Cen			03/28/07	L	ansdown	e, Maryland	
	Immediate Cause (Final disease or condition	ist only one cause on E (		AGE				or respiratory a			Approximate Interval Betwe Onset and Dea	
ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ex Due to		AQE uence of):							Interval Betwe	
sician/Medical	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. EY  Due to  c  Due to  d  23c. If yes, ou  1□Live	(or as a consequence of the con	AQE uence of): uence of): uence of):		A \				23d. Date of de Month	Interval Betwee	ath
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Registrar DHMH 17 Rev 1/2001 MAR 3 0 2007

Physici /Medi Examir		ANNE T.MCGRAW				2. Date of Dea		3. Time of Death
	cai i	AMED I . FICGRAM	1			March	28 <sup>ay</sup> 2007 <sup>ear</sup>	2:55 Рм
		4a. Facility Name (If not institution, give s 7838 Birmingham			4b. City, Town, or Location of Death Parkville		4c. County of Death Baltim	
Funeral Director		5. Social Security Number 218-12-2137  Usual Residence of Decedent	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birt Month, Da OCT • 26	y Ygard 22 Mar	place (State or Foreign Intry) Yland
/land		10a. State 10b. County	10c. 0	City, Town or Lo	ocation			10d. Inside City Limits
8e-f st	ctor	MD Balti	more	Pa	arkville			1 ☐ Yes 2 No
th with th	Funeral Director	10e. Street and Number 7838 Birmingha	m Avenue		10f. Zip Code 21 23 4		10g. Citizen of What Cou USA	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28e-f show apprintury or other traumatic evant. It is Medical Examination in the filed at ance.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No Rican, etc.)		
72 ho "natur	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	16b. Kind of Business/l	
within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		olic School Tea		St. Josep Elementary Sci	mol-Fullerton
be filed that Hygie ad other is evant. If	Be C	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
Ment Ment Marked Marked Marked	2	Harry G. Ta			Anna G.			
nd 2 sh lith and 27 ts m		19a. Informant's Name/Relationship (Type Eugene McGraw,		196. Mailir 7838	ng Address <i>(Street and Number or Ru</i> Birmingham Ave	ral Route Numbe enue-Pa	er, City or Town, State, Zi .rkville , M	<sup>ip Code)</sup> 21234 aryland
of Hea itam		20a. Method of Disposition	20b.	Place of Disoc	sition (Name of	Date	20c. Location - City or T	own, State
Page ment cant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State EV		natory or other place) AL CHAPPLAND Mar FRVICES BELAIR	2007	orest Hil	l,Marylan
permit. Depart Import eny inj		21. Signature of Funeral Service License	ne4	157	2. Name and Address of Facility JANS FUNERAL CHAPI ND CREMATION SERV		0 Harford Road	
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ath. Do not ent		or respiratory ar		Approximate Interval Between Onset and Death O MOMAS
sit ad	iner	Sequentially list conditions,	Due to (or as a cons	equence of):				
icate be executed physician and s the burial-transit	cal Examiner	cadas (Disease of Injuly that initiated events resulting in death) Last	Due to (or as a conse	equence of);				
The law requires that the death certificat te has been signed by the attending phy tage 2 should be delached for use as th	Physician/Medle	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 27 \( \text{No} \) 9 \( \text{Unknown} \)	3c. If yes, outcome of preg 1	tel death 3	⊒Ectopic pregnancy ] Other (specify)		23d. Date of deliving Month	very Day Year
w requires that the state of th	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause given in Part I.	23e. Did to	obacco use contribute to	
w requi	Completed					24a. Was	decolerations.	opsy findings available
The tav	omp					autop perfo		ompletion of cause of
	Be C	25. Was case referred to medical examiner?			26. Place of Dea			20140
Physician: r this certitic ral director,	ု	1 ☐ Yes 2 No		ER/Outpatier			lence 6 Other (Spec	ify)
ding After tune	ation:	27. Manner of Death  Natural 5 Pending  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury at Work?  M 1 Yes 2 No	28 escribe h	now injury occurred	
el or Attano s atter death it Director: id in by the	Certification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At building, etc. (Spec		eet, factory, office	28f. Location (S City or Tox	Street and Number or Rui vn, State)	ral Route Number,
To the Hospitel or At within 24 hours atter d To the Funaral Direct completely tilled in by	edical C	29a. Certifier Check only one) Certifying Phys	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge death nation and/or in	occurred at the time, date and place estigation, in my opinion, death occu	and due to the cred at the time,	cause(s) and manner as date and place, and due	stated, to the cause(s)
To the within 2 To the complet	Me	29b Signature and title of certifier	M	4/	29c. License number		29d. Date signed (Month)	, Day, Year)
	: 1	ILIT LOUIS 1616	7/ )[	11/	11 -11 -41		1 4 1 1 4 /	

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	For State	State of Mary	•	artment of F rtificate of i		Mental Hygie	ene	
# <sub>2</sub>		Registrar  1. Decedent's Name (First, Middle,	Last)		lilicate of	Deam	2. Date of Death		3. Time of Death
Physiciar /Medica		VICTORIA	T. MI	ELKE			MARCH 2	27,2007	10:22P M
Examine	10	4a. Facility Name (If not institution, 4226 WOODLEA				r Location of Death EBURG		4c. County of Dea	th A
Funeral Director		5. Social Security Number 220-03-3415	5. Sex 7. Age (In 1	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)	Year)   Co	thplace (State or Foreign ountry) RYLAND
*	- 1-	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
a-f sho ified at	.	,	N/A		RASP	EBURG			1 X Yes 2 □ No
Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 4226 WOODLEA	ΔVENIIE		10f. Zip Code	206	100	g. Citizen of What Co	•
er must	nera	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Mas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whi	erican Indian,
l", or its	o 고	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			1 □ Yes 2√2 No	Specify:			WHITE
dical E		15. Decedent's (Specify only highest	Education	(Give	dent's Usual Occup	during most of work		6b. Kind of Business	/Industry
than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired CEPTION	d) _		STELLA	MARIS
d other event, 1	Se -	17. Father's Name (First, Middle, La	ast) BLUM				ne (First, Middle, Ma		D.V.)
matic e	<u>-</u>	19a, Informant's Name/Relationship		19b Mailir	ng Address (Street	ANNA	K .	( GRAN]	
er traun		DOLORES CODD	/DAUGHTER			HT PLAC			MD 21093
or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	3 □Removal from State		matory or other plac	ce)		0c. Location - City or	
injury	-	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li	ecify) G					BALTIMOR	E, MD NERAL HOME
any ir		2 Control of the cont				SACO AV		EDALE, M	
sician		23a. Part . Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	omplications hat caused the nly one call on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	st, -	Approximate Interval Between Onset and Death
edical miner		resulting in death)	Due to (or as a cor	nsequence of):	me	tast.	10/h 25/5	-	
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a con	nsequence of).					
the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of);					
e buris	dical		d	, ,					
, eg	Ψ	IF FEMALE:	23c. if yes, outcome pf pr	roanonov				1	
shed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	livery Day Year
	by Ph	Part II. Other significant condition	s contributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
pinous							1 ☐ Yes	8 2 No 3 P	robably 4 Unknown
ge 2 st	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
irector, page 2 s	Φ	25. Was case referred to medical				26. Place of Dea	th (Check only one	No 1 □Yes	s 2 <b>50</b> No
	10 8	examiner? 1 Yes 2 No		2 ER/Outpatien		4 ☐ Nursing H	<del></del>	nce 6 Other (Spe	ecify)
funera	tion:	27. Manner of Death  12 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Wor	ryat rk? ∣Yes 2 ∐No	28d. Describe how	v injury occurred	
in by the	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ot be	I At home, farm, str pecify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	Medical C		Physician: To the best of my xaminer: On the basis of exa and manner stated.						
dwoo	Me	29b. Signature and title of certifier	MO		29c. Licens	2-53	7/ 29	d. Date signed (Mon	th, Day, Year) - 2007
\	-	30. Name and address of person w	the completed cause of death	(Item 23a) (Type,	Print)	21.00	Balls	270	mp - :
Circ		31, Date filed (Month, Day, Year)	60   - L-00   22. Registrar's S	N KOV Signature	ren //	104/	~-00110		21230
State	е	on bate med (moinin, bay, real)	L. Hegistial S						

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

(Month, Day, Year)

MAR 3 0 2007

MAR 3 0 2007

<b>.</b> .	or Print in Black Indelible Ink. Ensure All Co e of Maryland / Department of Health and Mental Certificate of Death			7 1014
ecedent's Name (First, Middle La	Tesha Moses	2. Date of Death  Month Day  March 27, 2007	Year	3. Time of Death 0742 hrs

artesna IVI. IVIOSE		State of Maryland / Department of Health and Mental Hyglene I- For State Certificate of Death Reg. No.
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last) Artesha Moses 22. Date of Death Month Day Year March 27, 2007 3. Time of Death 0742 hrs
an C	ı	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  University Hospital  4c. County of Death  Baltimore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. 1. 1. 2. 2000 Foreign
Director		J20 - 25 - 6325 1 M 2 VF NS
ow any		10a. State 10b. County 10c. City, Town or Location Battimore 10d Inside City Limits 1 Ves 2 No
ith the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
with the I s 23a or e notifie		726 N. Carey St.  11. Maryel Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene nt: If item 27 is marked other than "natural", or items 23a or 28a-f short traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
ours afte	od by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No specify: Specify: Old Graduation (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  Cashier  Boscovs
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be Cor	17. Father's Name (First, Middle, Last)  Arterus Moses  18. Mother's Name (First, Middle, Maiden Surname)  Petrice Randolph
D 2121 should be f and Mental ' is marked	To	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address, (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223  Petrice Masses - Mother  1315 W. Pratt St. Baltimore Mayland
re, MD 2  1 and 2 shou Thealth and ? fitem 27 is rer traumatic		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, place)  20c. Location - City or Town, State  20c. Location - City or Town, State
Baltimore, permit Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify: Mt. Zion Century 4207 Landsdowne, Maryland
	1	Jevin Park 3512 Frederick Are. Baltimore, Maryland
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or *eart failure. List only one cause on each line.  Immediate Cause (Final disease  a. Stab Wound To Chest  Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):
	iner	di any, leading to immediate cause. Enter Underlying Cause
rted 1	Examiner	events resulting in death) Last  Due to (or as a consequence of):  d.
be exect Sician an	Medical	UNPENDED AMENDED
fox 68760, each certificate be executed a attending physician and for use as the burial - transit	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown
, P.O. B ires that the d signed by the be detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
cords, law requir has been s	Completed	24a. Was an autopsy findings available prior to completion of cause of performed?
tal Recol	Com	1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one)
of Vita ing Physician After this cer uneral direct	To Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other  Nursing Home 5 Residence 6 Other:
on of ending F ath. or: After		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  1 Natural 5 Pending  28b. Time of Injury 32b. Time of Injury 28b. Time of Injury 28b. Time of Injury 32b.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse  28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 726 North Carey Street, Baltimore, MD
Hospit 24 hour Funers etely fill		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only)
To th within To th compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
		Panet Fredhold, mrs O.C.M.E. March 28, 2007
5		30. Name and eddress of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regist	ate rar	31. Date filed MAR 3 0 2007 31 Registrar's Signature
DHMH 17 Rev 1/2	001	ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 27 2007 Melvin Paul McDowe11 March 8:50 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Riverview Care Center Essex | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 29, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Mary Land 218-01-0195 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example from the modified at Yos 2 □ No Director Md Baltimore n /a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6904 Gough Street 21224 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 (∑X/es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any njury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 🕅 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) Butcher Esskay Meat Com. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Slunt Howard McDowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gertrude McDowell (wife) 6904 Gough St. Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 3/29/07 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caczorowski Funeral Home, PA 21. Signature of Funeral Service Lice 1201 Dundalk Ave. Baltimore, Md. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Onset and Death Immediate Cause (Final (10 Physician -3 mende disease or condition resulting in death) /Medical Due to (or as a conseq ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit that initiated events requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b 20 No 1 Yes 20 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Tes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred eral Director; After filled in by the funera Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospital o within 24 hours aff To the Funeral Di Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-38754 03-28-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 - BASTERN BWD, MD - 21221 141 WASEBM. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

07-02188 Dontrelle Nesmith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Time of Death Medical Examiner 2005 hrs Dontrelle Nesmith March 21, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3240 Normount Avenue N/A5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours Min 1 M Country) 220-96-7667 XXF 29 2/25/1978 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 No 28a-f show N/ABaltimore hours after death with the Maryland MdDirector 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country 3240 Normount Avenue 21216 USA 23a notif Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married White, etc. 1 Never Married 2 Yes 2XX No 20 4 X Divorced 3 Widowed If Yes, Give Year Yes 2X No specify: Specify: Black \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 l marked other than 'c event, the Medical 21215-0036 Self Employed Food Service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be and Mental <u>George Nesmith</u> Rose Nesmith 19a. Informant's Name/Relationship (Type, Print) nent of Health and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD George Nesmith Windsor Mills Rd., Baltimore, Md. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimo permit. Page Department o Important: injury or oth Loudon Park Cem. 3/30/2007Baltimore,Md. Other Specif 22 Name and Address of Facility Estep\_Brothers Funeral Home, PA. 1300 Eutaw Place., Baltimore, Md 21217 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or complications that cause, Approximate Interval Physician Between Onset and /Medical Death a No identifiable, anatomic or toxicologic cause of death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any leading to immediate Due to for es a conscioucion. A cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last B and Physician/Medical X UNPENDED g physician the burial .28a-f. perE. g866. 4/6/07 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year use as Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown by the a Unknown Part II. Other significant conditions o contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> Division of Vital Records, P. 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24b. Were autopsy findings available prior to completion of cause of autopsy has page 2 performed? death? certificate ✓ Yes 2 1 🗸 Yes 2 No Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other<sub>2</sub> Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 2 No After t 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Certification Natural death. Yes 2 X No Director: unk Fnd 3.21.2007 | Fnd 8:05 pm Accident Investigation e Funeral Direct etely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide determined (Specify) House 3240 Normount Ave. Baltimore, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 22, 2007 ord 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registra

Carlina .

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•		1 - State Registrar	State of Maryland	d / Department o		Mental Hygie	2007	10150
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici		Morris	F	lummer		March	Day Year	10 45 AM
)	/Medic Examin		4a. Facility Name (If not institution, give si	reet and number)		n, or Location of Death	1 laren	4c. County of Death	10 15
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yes. )	ist birthday) If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birth	9. Birtho	lace (State or Foreign
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	ס		Usual Residence of Decedent				(CC) Q 1		
	how How		10a. State 10b. County	10c. City	Town or Location			1	Od. Inside City Limits
	Ma Ma	to	MD Trince	Georges	La	re!			1 Yes 2 □ No
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ire	10e. Street and Number		10f. Zip Coo	ie	10g.	Citizen of What Cour	ntry?
	15 wil	a D	14200 Laurel	Park Driv	e i	20707		USA	
	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other then "natural" or items 23a or 28a-f show event, the Madical Examiner must be notified at	Funeral Director		2. Was Decedent Ever in U.S Armed Forces?		of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
စ္	or its		1 ☐ Never Married 2 ☐ Married	1 Yes 2 THO	1 ☐ Yes 2 ♣		riicari, etc./		etc.
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5	72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		one during most of work	ing 16t	b. Kind of Business/In-	dustry
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n n	tal H d of H	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Mai	den Sumame)	
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Maryland 21215-0036	2 sho	1	19a. Informant's New elationship (Typ		19b. Mailing Address (Sti	reet and Number Run	al Rojute Number, C	200	-> 20707
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department if the 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	1 3		mer (son)	14900 M	rue I Di	KM T		· · · · · · · · · · · · · · · · · · ·
Baltimore,	Pages 1 nent of H int: if ite iny or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		ace of Disposition (Name of metery, crematory or other	place	Date 200	. Location - City or To	own, State
Ë	permit. Pag Department Important: i any injury o		4 □ Donation 5 □ Other (Specify)	M	etro Cre	ACTON 4-	3-07	alto, Y	010
ä	permit. Departr importu any inju		21. Signature of Uneral Service License	//Y 1	22. Name and Ad	ddress of acility			0.4
_	E = 5.02		1 Jenoc	( are)	ZITIN	1232 MION	alley Dr.	JESSY?	PH 18434
			23a. Part1. Enter the disease, or complice shock, or heaft failure. List only one	ations that caused the death. cause on each line.					Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Anterios	constic C	andiovas	cular 1	28000	Over Learn
	/Medical		resulting in death)	Due to (or as a consequent					5 5 1
	Examiner		Sequentially list conditions, b.						
2	n =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):				
25	and and I-trans	Examiner	Cause (Disease or injury that initiated events c.						
0	e exe ian a urial-	ă	resulting in death) Last	Due to (or as a conseque	ence of):				
8760,	icate be executed physician and s the burial-transit	dical	d.						
9	ntifica ng pl	Med	IF FEMALE:						
Вох	eath certifi attending I for use as	an/	23b. Was decedent pregnant 23	<li>c. If yes, outcome of pregnant 1 Live birth 2 ☐ Fetal</li>		ancv		23d. Date of delive	,
	the at the at hed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea				Month	Day Year
P.O.	as of	Physician/Me	9 Unknown						
s,	gned se de	by	Part II. Other significant conditions cont	nbuting to death but not resul	ting in the underlying cause	given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
D D	w requires that s been signed t should be det						1 🗆 Yes	2 □No 3 □ Prob	ably 4 Dunknown
ပ္က	law re as be 2 sh	Completed					24a. Was an	24b. Were auto	psy findings available mpletion of cause of
Œ	The lavite has	E					autopsy performed 1  Yes 2 ☑	? death?	200 No
<u>a</u>	an: rtifica	a	25. Was case referred to medical			26. Place of Deat	h (Check only one)	12.103	
>	Physician: The la r this certificate has rat director, page 2	To B	examiner?  1 Tes 25 No	spital:	R/Outpatient 3□ DOA	/		e 6 □Other (Specif	v)
0	9 Ph erat		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c.		28d. Describe how		
Division of Vital Records,	or Attending ifter death. Director: After in by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Interior, Day 16al)		1 ☐ Yes 2 ☐ No			
Vis.	Atte	=	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor	ne, farm, street, factory, off	ice	28f. Location (Stree	t and Number or Rura	l Route Number,
	al or A s after of Direct	Certification:	4 - Hornicide	building, etc. (Specify)			City or Town, S	iaie)	
	To the Hospital or Attending Phywithin 24 hours after death. To the Funarel Director. After the Cumpletely filled in by the funeral		29a. Certifier 1 Certifying Physi	cian: To the best of my know	ledge, death occurred at th	e time, date and place,	and due to the caus	e(s) and manner as s	tated.
	he Hi 24 7e Fi	edical	(Check only 2 Medical Examinations)	and manner stated.	on and/or investigation, in r	ny opinion, death occuri	red at the time, date	and place, and due to	the cause(s)
	To the vithin 2 To the cumplet	ž	29b. Signature and title of certifier	AR .		ense number		Date signed (Month,	
				the en	M. J. D	002472	M	uch 305	2007
	ふ		30. Name and address of person who con	apleted cause of death (Item		01	4		
	J		SIEN SADIE	1433 LAU	REC KOWIE	L Kd. 5	T 208 L	AUREL, V	11 2070
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire				
100	Registr	ar	FERD O O 2007	4	South &				
DHN	1H 17 Rev 1/20	001	MAR 3 0 2007	prosess to	A STATE OF THE PARTY OF THE PAR				

	1 - For State of Maryland / Registrar	Department of Health and Mer Certificate of Death	Reg. No. 2007	10151
Physician	1. Decedent's Name (First, Middle, Last)  MARY A. RIESETT		Date of Death Month Day Year Arch 29,2007	3. Time of Death  2:05 P <sup>M</sup>
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Oakcrest Center	4b. City, Town, or Location of Death	4c. County of Death	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last i	Parkville birthday) If Under 1 Year   If Under 24 Hrs.   8.	Date of Birth (Month, Day, Year)  Baltin  9. Birth Cou	NOTE place (State or Foreign intry)
Director	217-01-1675			rland
yland how at	10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
he Mar Ba-f sl otiffied	MD Baltimore	Parkville	10-00	1 ☐ Yes 2 No
firer death with the Mar ritems 23a or 28a-f sh inher must be notified Funeral Director	10e. Street and Number 8830 Walther Blvd. Apt#229	10f. Zip Code 21234	10g. Citizen of What Cou	ntry?
r death rems 2 er mus	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric		
y xam y	If Yes, Give 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 █️No Specify:		ite
21215-0036 ed within 72 hours aff giene. er than "natural", or the Medical Exami	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Ir	ndustry
SETT 21215-00 ed within 72 hou ygiene. ner than "natura it, the Medical E	Elementary/Secondary (0-12) College (1-4or 5+)	Trust Officer	Mercantil	е
ind 2 be filled tal Hygin do other event, til	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)	
Maryland nd 2 should be file the and Mental Hy 27 is marked oth traumatic event	DOING DESITE KIESELL	9b. Mailing Address (Street and Number or Rural R	nes Warthwein	in Code)
H, Ma and 2 s and 2 s ealth an n 27 is u	Jean Rolle-sister	3347 Kennsington Squ	ıare-Manchester, Mar	yland
Baltimore, permit. Pages 1 a popartment of Her moportant: If item any injury or other page.	1 Burial 2 Cremation 3 Removal from State	of Disposition (Name of Date tery, crematory or other place)		
Iltim	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	wood Cemetery 4-2-07	Parkville,M	
Baltime Bartiment Department Important: I any Injury o	Condraé h ME tudde	AND CREMATION SERVICE	8800 Harford Road S Parkville,MD	21234
	23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line	o not enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)  Due to as a consequence	untua e of):	<u> </u>	
Examiner	Sequentially list conditions.	ovaxulas Accid	ient	
0, executed in and inal-transit Examiner	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events set librarie double) Leaf	9 Jf <sub>j</sub> .		
0, c	Due to (or as a consequence	e of):		
68760, C. liftcate be executed as the burial-transit edical Examir	d			
	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea	ath 3⊟Ectopic pregnancy	23d. Date of deliv	· ·
Fage 197 3: Records, P.O. Box (The law requires that the death certifier has been signed by the attending agge 2 should be detached for use a completed by Physician/Methods	in the past 12 moorts?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Unknown		Month	Day Year
IS, P. es that the igned by be detact		g in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ords equire equire sen sig			1 ☐ Yes 2 No 3 ☐ Pro	bably 4 □Unknown
0 a a c	2		24a. Was an autopsy performed? 24b. Were autopsy performed? death?	opsy findings available ompletion of cause of
		26. Place of Death (C	1 Yes 2 No 1 Yes	2 □ No
T this by C	1 Yes 2 No Hospital: 1 Inpatient 2 ER/		5 ☐ Residence 6 ☐ Other (Special	ify)
ng ng ng	27. Manner of Death  1 Natural  2 Accident  28a. Date of Injury (Month, Day Year)  2 Accident  28b. Date of Injury (Month, Day Year)	p. Time of	. Describe how injury occurred	
Division ( Ital or Attending F Its after death. Tal Director: After the funer the funer to the funer the f	3 Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office 28f.	Location (Street and Number or Rui City or Town, State)	ral Route Number,
pital of control of the control of t		dge, death occurred at the time, date and place, and	due to the cause(s) and manner as	stated.
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	(Check only one) 2 ☐ Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occurred	at the time, date and place, and due	to the cause(s)
with Tou	29b. Signalus and title of certifier	29c. License number D 3 5 6 8 5	29d. Date signed (Month)	, Day, Year)
4	39. Name and address of person who completed cause of death (Item 23a	a) (Type, Print) Blvd. Parl	culle, nD =	21234
State Registrar	31. Date filed (Month, Day, Year)  MAR 3 0 2007  Registrar's Signature	Soul ?		,

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

Yo the Funeral Director: After this certified

Be

P

Certification:

Medical

State Registrar

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

29b. Signature and title of certifier

29c. License number

10055325

March 26, 2007

29d. Date signed (Month, Day, Year)

MD 21532

Year

07

0510

Birthplace (State or Foreign Country)

10d. Inside City Limits

3 days

Year

4 Unknown

Day

1 ☐ Yes 2 No

Maryland

White

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

48 Terrace Frostburg WONSOCK MD SHIN MUSUIT

31. Date filed (Month, Day, Year)

2. Registrar's Signature

State

a

Registrar

29b. Signature and title of certific

w)0.5e-

MAR 3 0 2007

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

DO054725

1000 Franklin Square Drive Baltimore, Md 21237

29d. Date signed (Month, Day, Year)

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

					Otate of	iviai y iai		Certifica			Wio Mai Try	Reg. No.	11	10104
	=1		1. Decedent's Name (First, Midda	le, La:	st)	· · · · · · · · · · · · · · · · · · ·					2. Date of De	eth		3. Time of Death
	Physicia		Fotini G. R	iec	opoulis						MARC 14	Day 7	OA 5	10:00 AV
	/Medica Examine		4a Facility Neme (If not institutio			ber)			T	4b. City, Town, o	Location of Deet			
1	Examine	•	GENESIS HA	m/	LZON	Can-	7 DN			BAZT	IMPRZ			
-	Funeral		5. Social Security Number	6. S		. Age (In yrs.		day) If Unde	er 1 Year			th Year)	9. Birthp	place (State or Foreign
	Director		212-42-9507	1	□M 280 F	93	Yr	s. Months	Days	Hours Mir		7, 1914		• •
	P .	Ī	Usual Residence of Decedent											
	trylar thow		MD Balt		3.200	10c. Cit	y, Iown o	or Location	D	. 1 . 1 .			1	10d. Inside City Limits
	Be-f.s	5	IID Balt	TIHE	).e					edale				1 ☐ Yes 2 ☐ No
	if the		10e. Street and Number					10f. Z	ip Code			10g. Citizen of	What Cour	itry?
	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28e-f show any Injury or other treumatic event, to Medical Examinar mant to notified at once.	Funeral Director	4218 Kenwood	Ave	enue				1206			Greece		
	r dag	2	11. Marital Status		12. Was Deced Armed Ford	ent Ever in U, es?	,S.	<ol><li>Was Dece If Yes, spe</li></ol>	edent of ecify Cub	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No irto Rican, etc.)	)- 14. Ra Bla	ce - Americ ick, White,	
36	afte of H		1 Never Married 2 Mar		1 ☐ Yes 2 If Yes, Give	X□ No				Specify:			White	0
21215-0036	real,	Completed by	3 ☑ Widowed 4 □ Divorced		Year or Dat	es:								
7	net dice		15. Deceden (Specify only highe	it's Ed	lucation de <i>completed)</i>		16e. D	ecedent's Usi	ual Occu	pation during most of w ad)	orking	16b. Kind of B	usiness/in	dustry
12	A Paris	E	Elementary/Secondary (0-12)		College (1-4	4or 5+)				30)				
	filed v Hygie other t		17. Father's Name (First, Middle,	f a ati			ł	lomemak	ter	19 Mathor's No	ame (First, Middle	Own I		
JUE	be fi	å	George Pazar:										110)	
3	should be and Mental I and Mental I amarked of	₽					T				Margarit	-		
Maryland	2 sho	9	19a. Informant's Name/Relations	ship (1	Type, Print)			_			Rumel Route Numb Baltimore			Code)
	Health Health am 27 other tr	J	Eva Dardamanis			00h F		isposition (Na		Avenue	Date	20c. Location		Ctoto
9	Pages 1 nent of H int: If Ita iry or ot		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation	3 □	Removal from St	ate	emetery,	crematory or	other pla	ace)	Date	20c. Location	- City or 10	iwn, State
Ë	men men men men men men men men men men		4 Donation 5 Other (S			0al	clawr	ı Cemet			3/29/07			
Baltimore,	parmit. Pages Department of P Important: If its any injury or of pice.		21. Signature of Funeral Service	Licen /	ISOO						narles S			
ш	205 2 3		Hel					6224	East	ern Aver	nue Balti	more, M	D 212	224
			23a. Part 1. Enter the disease of shock or heart fallure. List	r comp	plications that cau	used the deat	n. Do no	t enter the mo	de of dy	ing, such as cardi	ac or respiratory a	rrest,	1	Approximate Interval Between
	Physician	4	Shoot Frout railayo. Elst	. O y	0110 04400 011 041	5/1 II/10.							1	Onset and Death
	/Medical	- 1	Immediate Cause (Final disease or condition		GUD	STAG	8	non	an.	TIA			1	
	Examiner	1	resulting in death)		a			nsequence of					- 1	
-	ر ج	ē											1	
	law requiras that tha death certificata be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	E	Sequentially list conditions.		b. ————	Due to (o	rasa coi	nsequence of	):					
ó	an ar rial-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):								i				
68760,	ta be ysicii	8 0	that initiated events		C	Due to (o	r as a cor	nsequence of)	:					
89	ing ph as th		resulting in death) Last	l									1	
Box	that tha death cert ned by the attending detached for use				d								1	
	deat e attr	Physician	Part II. Other aignificant condition	ons co	ontributing to dea	th but not resi	ulting in th	ne underlying	cause g	iven in Part I.	23b. Did	tobacco use co	ontribute t	o the cause of death?
P.0	t tha by th tache	<u> </u>									10	Yes 2 No	3 □ Pro	bably 4 Unknown
	as that igned be del	8												
of Vital Records,	quira on sig										24a. Was	an autopsy		ere autopsy findings vailable prior to
00	w require s been si should										Pont	Jillieu:	co	mpletion of cause death?
æ	The law ata has paga 2	Completed									10	Yes 20 No	- 1[	□Yes 2□No
ā	certificata		25. Was case referred to medica	1						26 Place of D	eath (Check only	** *** ***		2100 22100
Ē	Physician: r this certificated director,	o ne	examiner?		Hospital:	nationt 2 🗆	ER/Qutp	atient 3 D	01		Home 5□Resi		her (Specii	6/)
of	Physical distribution	-  -	27. Manner of Deeth		28a. Date of	Injury	28b. Tin		28c. Inju			how injury occu		77
on	ding h. Afte		1 Natural 5 Pendir 2 Accident investi		(Month,	Dey Year)	Inju	ıry M		ork? ]Yes 2∐No				
S	Attanding or death.	<u> </u>	3 ☐ Suicide 6 ☐ Could	not be		f Injury - At ho	ome, farm	ı, street, facto	ry, office				ber or Ruri	al Route Number,
Division	after Dire	Certification:	4 ☐ Homicide	illiou	building	, etc. (Specif	v)				City or To	wn, State)		
	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificata ht completely filled in by the funeral director, paga	2	29a. Certifier 1 certifyin	ng Ph	ysician: To the b	est of my kno	wledge. n	leeth occurred	dat the t	ime, date and place	e, and due to the	cause(s) and m	anner as s	stated.
	24 h 24 h Fur etely	edical	(Check only 2   Medical	Even	draw On the hee	in of overmine	tion and/	ar inventiontio	n in my	oninion doubt no	surred at the time	date and place	and due to	o the cause(s)
	othin ompl	M	29b. Signature and title a certifie	or ,	. 0	0	- 50 - 25	25	c. Licen	se number		29d. Date sign	ad (Month,	Day, Yeer)
	F 5 F 0		7/	1	TOPICA	2 477	000	11.9	DA	0 622:	39	MAKE	2 27	L 2002
	1)	.	30 Name and address a parson	who	completed course	of death (How	2361 /7	(ne Print)	700	10111	transce of	W / D	075	u
	1		BA	W110 6	MATRE-	or death (11911	MA	W KIN	200	( )	HMICIC	IN CON	- 60	
	Can		31. Date filed (Month. Dav. Year)	-10	32.	gistrer's Signa	ture		-	1 00	( MI)			
	State Registra	r	29b. Signature and title of certifie  30. Name and address of person  31. Date filed (Month, Day, Year)	0 2	007	191A8-5	K	Connect	9					
			1717"\1\ \	nor for	But 63	100	- 1	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 26 10:41 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mercy Medica a Himore enter Year If Under 24 Hrs. 8. Date of Birth
Min Month, Day, 6. Sex 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🖫 F Yrs Director 217-54-2033 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ 110 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Department of Heelin and Mental Hygiene. Important: If item 27 is marked other then "naturally or other treumating." 7511 2120 .S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ecretar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sui Be ဥ Sista 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7511 - ber 21207 D lapriz 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory of 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -200 22. Name and Address of Page 21. Signature of Funeral Service License Cullok 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires thet the death certificate be executed Exami ed by the attending physicien and detached for use as the burial-trathat initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown this certificate has been signed by ral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 🗌 Yes 2 🗌 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 1 Yes 1 Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 20 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 27: Manger of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Natural
2 Accident 5 ☐ Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the hest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Michael Grassi Pau 31. Date liled (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 3 0 2007

State

DHMH 17 Rev 1/2001

0

Registrar

29b. Signature and title of certifier

MICHAEL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN,

D

MAR 3 0 2007

mo

32 Registrar's Signature

29c. License number

041968

29d. Date signed (Month, Day, Year)

1602 Belair Rd. Baltimore, MD 21236

Physici	an	1. Decedent's Name (First, Middle, Last)  Et loop Toy Coott		Certificate of Deat	2. Date of De	Reg. No. ath 28, 2007	3. Time of Deat
/Medic Examir	cal	Eileen Joy Scott  4a. Facility Name (If not institution, give street and nu	imber)	4b. City, Town, or Locatio		4c. County of Death	7:20 A
Examili	Iei	Ivy Hall Geriatric Cente	ŕ	Middle Rive		Baltimore	
Funeral Director		5. Social Security Number 220–20–1610 6. Sex 1	7. Age (In yrs. last birth 80 Y	nday) If Under 1 Year If Under 1 Year Months Days Hours	er 24 Hrs. 8. Date of Birt (Month, Da 1 1 / 1 2/		place (State or For htry) Land
Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore	10c. City, Town Essex	or Location		1	10d. Inside City Lin
th with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 730 Essex Avenue		10f. Zip Code 21221		10g. Citizen of What Cour	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic evant, it is Mydical Examinar must be notified at ODGe.		11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dec Armed F. 1 Yes, Girls Year or D.	2 <b>∑</b> No ive	13. Was Decedent of Hispanic of If Yes, specify Cuban, Mexic 1 ☐ Yes 2X No Specify		Consider	
within 72 ho ene. than "natur ne Mudical	Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	1-4or 5+)	Decedent's Usual Occupation 'Give kind of work done during m life. DO NOT use retired) Cretary	ost of working	16b. Kind of Business/In Medical Pub	
uld be filed Mental Hygi Irked othar Itic evant, II	To Be Co	12 17. Father's Name (First, Middle, Last) Albert Burgemeister	bec	18. Mo	ther's Name (First, Middle, lian Pyle		TISHING
and 2 sho laith and I 1 27 is ma ar trauma		19a. Informant's Name/Relationship (Type, Print) Larry Scott (Son)		Mailing Address (Street and Num 28-A Essex Avent			
Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition  ↑□ Surial 2 □ Cremation 3 □ Removal from  • 4 □ Donation 5 □ Other (Specify)	State cemetery	Disposition (Name of crematory or other place)  S Of Faith	Date 03/30/2007 ]	20c. Location - City or To Baltimore, M	
permit. Departr Importa any inje		21. Signature of Funeral Service Licensee		22. Name and Address of Fac Bruzdz 1 1407 Old Eas	inski Funera. Lern Avenue.	l Home, P.A. Essex, Mary	land 212
Physician /Medical Examiner		resulting in death)  Due to	Actasta - (or as a consequence of	tic Sara	as cardiac or respiratory ar	rest,	Approximate Interval Betwee Onset and Deat
ate be executed by sician and the burial-transit	ical Examiner	Cause (Disease or injury that initiated events c.	(or as a consequence of				
inal the death certified of by the attending pt detached for use as to	Physician/Med	in the past 12 months?	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
quires that in signed b uld be det	by	Part II. Other significant conditions contributing to d	eath but not resulting in	the underlying cause given in Par		obacco use contribute to the	
uctan: The law requii certificate has been s rector, page 2 should	Completed				24a. Was autop perfor 1 ☐ Yes	prior to contrained?	psy findings avai mpletion of cause 2 No
ding Phys	ation; To Be		Inpatient 2 ER/Outpot Injury 28b. Tin	patient 3 DOA Other: 4K			y)
in Direct	Certification:	4 Homicide build	e of Injury - At home, farring, etc. (Specify)		City or Tow		
	20	29a. Certifier (Check only (Ch	asis of examination and	death occurred at the time, date for investigation, in my opinion, de	and place, and due to the c eath occurred at the time, c	cause(s) and manner as st date and place, and due to	tated. the cause(s)
To tha Hospital within 24 hours a To tha Funaral I completely filled	Medical	one) and man 29b. Signature and title of certifier	iloi statou.	29c. License numbe	,	29d. Date signed (Month,	Day Vosel

07-02396 Joseph Lambert Sidor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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-		U	1	0	No.	J	ĺ

		Registrar		Ce	rtificat	e of	Death				Reg. No			
Physicia Medical Examir	ın/	Decedent's Name (First, Midd								Date of De	eath Dav	Year		e of Death
Medical Examile	iei	Joseph 4a. Facility Name (if not institution	Lamb	ert_		- [4	Sidor o. City, Town, o	or Location o		March 28	3, 200	7 c. County o	11	53 hrs
		12 Arrowship Rd	on, give on ook and mann	5017		[ ]	Dundalk	or Eocation c	or Death		1	Baltimore		
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthd	ay)	If Under 1 Ye	ar If Unde	r 24Hrs.	8. Date of E	Birth (MM	I/DD/YYYY)	9 Birthplace	(State or
Director		216-66-3178	1 M 2 F		51	Yrs.	Months Da	ys Hours	Min.	Novembe	r 11.	.1955	Foreign Country)	Maryland
		Usual Residence of Decedent										1333	_	riar y ranc
w any		10a. State 10b. County		10c. City	, Town or									nside City Limits
Aaryland 28a-f show 1 at .nc.	ភ្ន	MD. Balti	more		Colg	ate							1 _	Yes 2 X No
Mary r 28a	Director	10e. Street and Number					10f. Zip Code				10g. Cit	tizen of Wha	at Country?	-
ith the 23a o notifi		249 Colgate Av					2122					US		
death with the Maryland or items 23a or 28a-f sho must be notified atec.	Funeral	11. Marital Status  1 Never Married 2 N	12. Was Deced	es?	.S. 1		Decedent of H s, specify Cuba				lo-	14. Race - White,	American Ind etc.	ian, Black,
fter de !", or er mu		3 Widowed 4 XDiv	1 Yes vorced If Yes, Give Year	2 X No		1 .	res 2 X N	o specify:				Specify: V	White	
ours at	a p	15. Decedent's Education (Spe	or Dates:	completed)	16a. De	cedent's	s Usual Occup	ation (Give k			16b.		iness/Industry	
72 hc	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	dur	ring mo:	st of working lif	e. DO NOT	use retired	4)				
vithin ene.	g l	12 years			La	bor	er				Re	ed Sta	ar Yeas	t Company
1215-0( Id be filed wi Mental Hygien narked other event, the M		17. Father's Name (First, Middle	e, Last)					18 Mother	s Name (F	irst, Middle	, Maiden	Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To Be	Stephen A. Sidor  19a. Informant's Name/Relations	ship (Type Print )		19b N	Apilipa	Address (Stre	Dora F				· · · · ·	01-1- 7: 0-	.1-3
O g B z i	۲	Theresa M. Smi		er			lgate A							ide)
and and treatth item	ŀ	20a. Method of Disposition		20b.	Place of D	) ispositi	on (Name of co	emeterv		oate 3,			City or Town, S	State
nor ages ont of other	1	1 Burial 2 XCremation	-	State Ba	crematory YVie	or othe	r place) remator	v	Apri 200		Ba1	ltimor	e City	. MD
Baltimore, MD pennit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati	ŀ	4 Donation 5 Other S 21 Signature of Funeral Service	Licensee	20				_					_	, I.D.
Per Per in		Methouse	Connel	Sen-		71	me and Address 10 Soll	Funera	al Ho Sint	me Oi Road	Dur	ndalk,	P.A.	222
Physician		23a. Part I. Enter the disease, or failure. List only one cause	r complications that caus	sed the death	. Do not e	nter the	mode of dying	, such as ca	ardiac or re	espiratory a	rrest, sho	ock, or hear	t Appr	oximate Interval
/Medital. Examiner	1	Immediate Cause (Final disease	A . 1 7	rotic ca	ardiov	<i>ras</i> cu	lar dise	ase					Detv	veen Onset and Death
Examiner	-	or condition resulting in death)	Due to (or as a co											
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	neeguence o	νf)·									
	اڃَ	cause. Enter Underlying Cause (Disease or injury that initiated		onsequence o										
ed	Examiner	events resulting in death) Last	Due to (or as a co	onsequence o	of):									
3760, ficate be executed g physician and s the burial - transit		X UNPENDED	d.											
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38760, rtificate bu ing physic as the bur	틽	23b. Was decedent pregnant in the past 12 months?	he 1 Live birth			Feta	I death 3	Ectopic	pregnanc	у	23	<ul><li>d. Date of d</li><li>Month</li></ul>	Day	Year
Box 61 e death cert the attendir	Sici		known	t at time of de	eath 5		er (Specify)				1390			
P.O. Box 66 s that the death cert gned by the attendir	Physicia	Part II. Other significant condit	9OHKNOW		acultina in	thoup	dorlying on too	sives in Bo	-4 I	230 Did	tobacco	use contrib	ute to the cau	no of dooth?
P.O es that t igned by	হ	. a.c. iii otiloi olgiiilloant oolidii	dens contributing to di	eath but not n	esulting in	i ti ie di i	derrying cause	giverriirrai	1.				_	Unknown
ords, P w requires t as been sign should be c	Completed			• •						24a. Was	s an	I 24b. W	ere autopsy fii	ndings available
COF law r has b	힏							<del>.</del>		auto	psy ormed?		or to completi ath?	on of cause of
tal Recision: The certificate		05.144									2 N	1 0	<b>✓</b> Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	mॅ	25. Was case referred to medical examiner?	Heavital:	atient 2	ER/Outpa	ationt		Other		y one) Home 5	Booide	2000 6 6	Other: Scene	
of V g Phys ter thi	음.	1 Yes 2 No 27. Manner of Death	28a. Date of (Month, Date)		28b. Tim			ury at Work?	•			ury occurred		
OD C	틸	1 X Natural 5 Pen	(Month, Da	ay,Year)		,	·	Yes 2	No		,			
r Attend er death.	lg		estigation 28e. Place of	of Injury - At h	ome, farm	, street,	factory, office	building, etc	28	3f. Location	(Street a	and Number	or Rural Rout	e Number, City
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  The law requires that the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	odicide	Id not be (Specify)				•		- 1	or Town,				
Hosp 24 ho Fune rtely fi		29a Certifier	hysician: To the best o	f my knowled	ge, death	occurre	ed at the time, o	date and pla	ce, and du	e to the cau	ıse(s) ar	nd manner a	as stated.	
To the Hospita within 24 hours To the Funeral completely filler	Medical	one) 2 Medical Exa	miner:On the basis of e and manner state		and/or inve	estigatio	n, in my opinio	n, death occ	curred at th	ne time, date	e and pla	ace, and du	e to the cause	(s)
	Σ	29b. Signature and title of certific	er	10.				se number					(Month, Day	, Year)
		Moti Uron	ica-Yol	lat	دسمه س		O.C	.M.E.			Mar	rch 29, 2	007	
	ſ	30. Name and address of person	•	,	,		144 D		141	ND 040		•		
		Patricia Aronica-Polla		t Medical I strår's Signatu		er '	I11 Penn S	ireet, Bal	ıtımore,	IVIU 2120	וינ			
Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Re	ouers Signatu	M	1	10 m							
DHMH 17 Rev 1/200	_	2 2 2 2 2 2	~ \(\frac{1}{2}\)		ORIG	INIAI		<u> </u>						
					01/10									

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 125-000 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Mulhearn, M.D. 31. Date filed (Month, Day, Year) MAR 3 0 State 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Anna May Schaffer 2007 March 7:00 A.M /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Towson Baltimore County Towson If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 217-26-7137 Director Aug. 3, 1929 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore County 28a-f sh notified 1 □ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or items 23a 509 E. Joppa Road 21286 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXXVo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status "natural", or item Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2CXNo þ Specify Specify: White 3 ☐ Widowed 4 X Divorced Completed th and Mental Hygiene.

7 Is marked other than "natul traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 12 Office N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. Redmon Myrtle R. Clifton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Ms. Cheryl L. Schaffer (Daughter) 4 Glenamoy Road unit 201, Timonium, Maryland 21093 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. ŏ Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road, Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician erebrovascu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner rop Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine aw requires that the death certificate be executed the burial-trai resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 1□ Yes 2□ No 1 TYes director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this nours after death.

neral Director; After this y filled in by the funeral di 27. Manner of Zeath 1 Watural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Division or Vital Records, within 24 hours a

To the Funeral I

completely filled To the Hospital

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29b. Signature and title

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7600 OSLER Dr. TOWSON MD 21204

31. Date filed (Month, Day, Year)

and manner stated.

2-0012849

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year KENNETH L. SIMON 12:10 PM 03 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN N/A BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/23/1951 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months MARYLAND Director 216-48-3464 Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12 BIDEFORD COURT 21234 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 4 YEARS ACCOUNTANT SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Health and Mental CARVILLE SIMON WINIFRED GRIFFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH A. SIMON/WIFE 12 BIDEFORD COURT BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 3/31/2007 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service License 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a art1. Enter the disease, or omplications of the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner URINDRY IN FECTION, DECUBITUS ULCERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4☐ Pregnant at time of death Day 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ACUTE RENAL FATLURE 2 No 3 Probably 4 Unknown MYOLARDIAL INFARCTION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate PNEUMONIA 1 Yes 2 140 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 THE 1 atient 2 ER/Outpatient 3□ DOA 27. Manner of ath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Cindural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident the f within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) Gragosam P-18943 3-28-2007

State Registrar DHMH 17 Rev 1/2001

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Baltimore,

death certificate be

P.O.

Division of Vital Records,

31. Date filed (Month, Day, Year) MAR 3 0 2007

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAIDEEP HINGORANI

MO 21239

Physician

/Medical

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification: To

Medical

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6 State Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 1:20A M March 200.7 Olga Evelyn Shoan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 6 SAV 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F 340-16-1551 88 Director Aug 25, 1918 Illinois Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at show 1 ☐Yes 21X No. Maryland Baltimore Catonsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 1 "natural", or items 23a or 912 South Rolling Road Apt 9 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event. the Natural once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No <u>Ş</u> Specify: White 3 XWidowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Swan Nelson Hanna Erickson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wendy C. Shoan 22 Triple Crown Court; Baltimore, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/27/2007 Metro Crematory Catonsville, Maryland 4 □ Donation 1 5 □ Other (Specific) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Ameral Servic Licens 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reu morua **Physician** 2 Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidne disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 42 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes performed 2 □ No 20 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March, 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAGAI MEGNA Avenue 1 B Mtimere Citon MD 2122 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		A Comment	epartment of Health and N Ce <i>rtificate of Death</i>	lental Hygier Reg. N	6001 10104
Phys	sician	Decedent's Name (First, Middle, Last)  A	600	2. Date of Death Month	Day Yeer 3. Time of Death
/Me	dical miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Glen Bt	3 2	4 07 And Anne Arundel
		Manner Health of Glen Burnie			
Funer Direct		5. Social Security Number 047-20-9156 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birth 83 Yr	Months Days Hours Min	8. Date of Birth (MPeb Bay) 92	9. Birthplace (State or Foreign Co <b>winginia</b>
Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of Maryland N/A	or Location Baltimore		10d. lookide City Limits 1 ☑ Yes 2 ☐ No
h with the	i Direc	10e. Street and Number 4923 St. Gemma Road	10f. Zip Code 21229	10g. C	Citizen of What Country?
portition of a should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Itams 23a or 28a-1 show any injury or other traumatic evant, in Medical English at marked.	by Funeral Director	11. Marital Status  1  Never Married 2 Married  1 Never Married 2 Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2  No   Yes Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Black Specify:
within 72 h iene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) ((Specify only highest	recedent's Usual Occupation Give kind of work done during most of worki rie. DO NOT use ratired Employee	ng 16b.	Kind of Business/Industry Bethlehem Steel
2 should be filed within and Mental Hygiene. is marked othar than aumatic evant, the Me	To Be C	17. Father's Name (First, Middle, Last)  James Miller	18. Mother's Name	(First, Middle, Majde	Miller Marian
and 2 should and 2 should ealth and Men n 27 is marke		19a. Informant's Name/Relationship (Type, Print)  William L. Brown Nephew	Aailing Address <i>(Street and Number of Rura</i> 7840 Shellye Road Glen Burn	il Route Number City nie, Maryland 2	1060", State, Zip Code)
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)		pate 20c. 1	Location - City or Town, State Lansdowne, Maryland
permit. Departr Importa	SUCE.	21. Signature of Funeral Service Licenses	22. Name and Brothers Funera 1300 Eutaw Place Bar	al Service, P. A. timore, Md 212	217
Physicia /Medic Examine pur un and	al	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Due to (or as a consequence of)	STRUCTIVE RTERY DISE IAL HYPE	PULMO	NAP Approximate historial Between Post and Between Post a
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical I	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  d.  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Late of delivery Month Day Year
w requires that been signed I should be det	۵	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
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or Attanding Physiter death. Director: After this in by the funeral dir	Certification: To B	examiner?  1  Yes	e of 28c. Injury at york?  M 1   Yes 2   No	ne 5 Aesidence 8d. Describe how inju	ury occurred  and Number or Rural Route Number,
To tha Hospital or within 24 hours afte To tha Funaral Dir completely filled in	ledical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, described by the desired physician and manner stated.	eath occurred at the time, date and place, a r investigation, in my opinion, death occurre	nd due to the cause(sed at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier	29c. License number	0 MAR	ate signed (Month, Day, Year) CH 27, 2007.
1		30. Nather part across of person who completed chure of least (Itely 282) 750	90, Prins 410 - A PT	CHIE	HIGHWAY,
S Regis	state strar	31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	de la	-	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:30 a Harriett Tapp Physician Mar 27, 2007ear /Medical 4b. City, Town, or Location of Death.
Baltimore 4c. County of Death N/A 4a. Fecility Name (If not institution, give street and number) Examiner Sinai Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Months 5. Social Security Number 217-34-1117 7. Age (In yrs. last birthday) 72 Birthplace (State or Foreign Coultraryland **Funeral** 1 M 2 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Madical Examiner must be notified at Maryland N/A **Baltimore** Director 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 5015 Yellowwood Road 10f. Zip Code 0.0 21229 Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after permit. Pages I and 2 should be filled within 72 hours aft.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or heny injury or other treumatic event, the Medical Examinance. 1 Never Married 2 Married Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Baltimore City School System Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)
James W. Tapp Maryland 18. Mother's Name (First, Middle, Maideo Surname) Be ပ 19a. Informant's Name/Relationship (Type, Print) Sabrina Harper Daughter 19b. Mailing Address (Street and Number or Burgl Boute Number, City or Jave, State, Zip Code) 5015 Yellowwood Road Baltimore, Maryland 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Veterans Cemetery 04/01/07 Owings Mills, Md. 4 ☐ Denation 5 ☐ Other (Specify) e of Funeral Service Liberal 22. Name Estep Brothells Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 316/ANY /Medical Due to (or as a consequence of): Examiner On Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) betes Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Division of Vital Records, P.O. Box 68766代以 Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ete has been signed by the atter page 2 should be detached for u in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificete 212 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient examiner' 1 Yes 2 No 2 Proutpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DQA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 CU 30. Name and address/of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 0 2007 Registrar

HARRIET

			1 _ For State	State of M	aryland / Dep	artment of F rtificate of		Mental Hygi	iene		
			Registrar  1. Decedent's Name (First, Middle	Last	Ce	runcate of	Dealli	2. Date of Deat	eg. No.	3. Time of Death)	
П	Physici	an						Month	Day Year	1	
	/Medio		WILLIE 7 4a. Facility Name (If not institution			4h City Town o	r Location of Death	MARCI	4c. County of Dea		
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	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			
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	he M	Director	MD N,	A	Ват	cimore			**		
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Maryland	d 2 sh th and 7 is r treur		19a. Informant's Name/Relationsh			,			City or Town, State.		
	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Plygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 ehoy other treumatic event, the Medical Exammer must be multified at		Robert Torair 20a. Method of Disposition	/Brotner	20b. Place of Disp	osition (Name of			e, Md 21		
no	Pages 1 and 2 ment of Health s ant: If item 27 is ury or other tre		1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (Sp	3 □Remove from State	1	matory or other place			2007 Balt		
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Euneral Service	- 11	2	2. Name and Addres	ss of Facility	-			
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	The law requires that the death cert ite has been signed by the ettendin.	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at		⊒Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year	
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ord	w requir been si should	ted						1 🗌 Ye	s 2□No 3□P	robably 4 Dbnknown	
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isi	death death stor: / the	icat	2 Accident investig	ot be	ury - At home, farm, st		Yes 2 □No	28f Location /Str	reet and Number or R	ural Route Number	
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)			> South	ND		Doc	53150	0 1	YARCH &	25th 2007	
	3		30. Name and address-of person	completed cause of d	leath (Item 23a) (Type,	Print)	- , h	RO	0-0,5	ute 110	
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(-3		Examiner			Due to (o	ras a conseq	uence of):								
in de la company				Sequentiafly list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								
0		cate be executed physicien and tha burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or	r as a conseq	uence of):								
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914-2r	Вох	that the death certif ed by tha ettending detached for use a:	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		ome of pregna h 2 ∐ Feta nt at time of d	fdeath 3[	∃Ectopic p					2	23d. Date of defi Month	very Day Year
3/6	0.0	at the d by tha	hysi	9 Unknown	9□ Unknow										
, -	ds, F	sign d be		Part II. Other significant conditions con CONGESTII	ntributing to dea	th but not res	ulting in the u	nderlying AIL	UR.	n in Part	l.		obacco u Yes 2[		the cause of death?
9	Vital Records,	e law requ has been je 2 shoul	Completed									24a. Was		24b. Were au	topsy findings available completion of cause of
ac	Œ Œ	: The	Com									autor perfo	ormed?	death?	2₽No
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>	J of	ding Phys	n: To	27. Manner of Death	28a. Date of		28b. Time of Injury		28c. Injury Work	4 LT N		8d. Describe		Other (Spec	afy)
t	Division	Attending r death. ector: After	catio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M	101	es 2	]No				
incent	Divi	4 hours efter death 4 hours efter death Funeral Director: / aly filled in by the f	Certification:	4 Homicide determined	28e. Place o building	f Injury - At ho , etc. <i>(Specif</i> )	ome, farm, str y)	reet, facto	y, office		2	8f. Location (: City or Tox	Street and wn, State,	d Number or Ru )	ral Route Number,
Sir		To the Hospital or Attending Physicien: The la within 24 hours elter death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier 1 Certifying Physical Check only one)	sician: To the b ner: On the bas and manne	is of examina	wledge, death tion and/or in	h occurred vestigation	at the tim	e, date a inion, de	nd place, a ath occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
		To the within 2. To the complet	Me	29b. Signature and title of certifier		A0 A			c. License		176	CA	29d. Dat	e signed (Monti	o, Day, Year)
		1		1 Lefon Au											,2007
	_	, U		30. Name and address of person who co					LADE	LPHI	A RD	STE 2	108.	BALTIMO	TEE, MO 21137
		Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2007	32. Rec	gistrar's Signa	ture								

07-02385 **Doris Wright** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Medical Examiner Month Month Day March 28, 2007 1000 hrs Doris

4a. Facility Name (if not institution, give street and number) Wright 4b. City, Town, or Location of Death c. County of Death 3240 Kenyon Avenue 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 217-30-4317 Director Months Days Hours М 2 X F Country) 10-31-1932 74 VA Usual Residence of Decedent 2 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. MD NA 1 X Yes 2 No Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3240 Kenyon Avenue 21213 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Examiner must be 14. Race - American Indian, Black. Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes 3 X Widowed Black 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done mit Pages I and 2 should be filed within 72 hour wrment of Health and Mental Hygiene.
rtant: If item 27 is marked out Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel 10th grade NA Outside Machinest 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Robert Gates Estelle Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Wright - Son 3240 Kenyon Avenue Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Anne Arundel Co, Md Department o Cedar Hill Cem 4-4-2007 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East 21202 1101 E. North Avenue Balto MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last - transit and Physician/Medical UNPENDED the attending physician ed for use as the burial -AMENDED Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available autopsy has prior to completion of cause of death? this certificate Yes 2 V No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Other<sub>4</sub> DOA Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 2 No After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Pending 1 Yes 2 No To the Funeral Director: the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 29, 2007 hna Brasiel 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month) Pay Year State 32. Registrar's Signature THE STATE OF

Registra

7-02305 Imber Nicole W		ms Si	<b>pe or Print i</b> tate of Maryl	and / Depa	artment c	of Health a			gible. 201	17 1016
		1- For State Registrar		Cei	rtificate c	of Death			g. No.	2/ 1010
Physicia Medical Exami	ner	1. Decedent's Name (First, Midd Amber Nicole	William	ns				2. Date of Deat Month March 25,	Day Year 2007	3. Time of Death 2136 hrs
		4a. Facility Name (if not institution 44½ East Franklin St		umber)		4b. City, Town, Hagerstov	or Location of Dea vn	ith	4c. County of De Washington	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye		rs. 8. Date of Birt	h(MM/DD/YYYY) 9.	Birthplace (State or
Director		214-15-4189	1 M 2X F		28 yr	Months Da	ays Hours M	Jan 1		reign Country) MD
_		Usual Residence of Decedent								
ow any		10a. State 10b. County	inaton (		Town or Loca					10d. Inside City Limits  1 Yes 2 No
e Maryland or 28a-f show <u>fied at once.</u>	햙	MD Wash	ington (	o Mau	igansv	1 L L C 10f. Zip Code		110	g. Citizen of What C	- 21
th the Maryland 23a or 28a-f she notified at once	Director	13844 Greenf	ield Ave	enue		2176			USA	,
) 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once		11. Marital Status		cedent Ever in U.				Specify Yes or No-		nerican Indian, Black,
or iter	Funeral	1 X Never Married 2 N	1 Yes	2 🗶 No	"		an, Mexican, Puer	to Rican, etc.)	White, etc	
rs after ural", miner	畜	3 Widowed 4 Div	vorced If Yes, Give Ye or Dates:		1 16a Decede	Yes 2 X N	lo specify: pation (Give kind o	f work done	Specify: What 16b. Kind of Busine	
2 hour	eted	Elementary/Secondary (0-12)		1-4 or 5+)			fe. DO NOT use re		TOD. KING OF BUSINE	SS/II I GUSTI Y
5-0036 led within 72 hours afte tygiene other than "natural", the Medical Examiner	Completed	10	N/A	A	Di	sabled			_Disabl	ed
15-0 filed v Hygird d other	- 1	17. Father's Name (First, Middle						ne (First, Middle, M		
21215-0036 Juld be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be	Thomas Phill  19a. Informant's Name/Relations	1 D W1 LL I ship (Type, Print)	ams	19b. Mailir	ng Address (Str	Debor eet and Number o	<u>ah Palu</u> r Rural Route Num	cki ber, City or Town, St	ate, Zip Code)
O g E is E		Deborah Lill	ey-Mothe	er	1384	4 Green	nfield	Ave. Ma	ugansvil	1e, MD 2176 or Town, State
		20a. Method of Disposition  1   Burial 2 Crematio	n 3 Removal f		Place of Dispo crematory or o	sition (Name of o ther place)	emetery,	Date	20c. Location - City	or Town, State
imore Pages 1 nent of H cant: If i	Ш	4 Donation 5 Other S			.Stan	islaus	Cem.3-	30-07	Dundalk	, MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Euneral Service	Licensee		22.	Name and Addre	ess of FacilityKa	czorows	ki Funer	al Home,PA
Physician	$\dashv$	231. Part I. Enter the disease, or	complications that	caused the death	Do not enter	the mode of dyin	ndalk A' g, such as cardiac	ve,BaL or respiratory arre	timore.M	Approximate Interval
/Medical	-	failure. List only one cause Immediate Cause (Final disease		cations of	diabete	s mellitus	3			Between Onset and Death
Examiner		or condition resulting in death)		a consequence o						
	-E	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	ıf):					
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ecuted and transit		events resulting in death) Last	d.	a consequence o	17):					
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760, cate be physic the bur	/Mec	IF FEMALE:	23c. If yes,	outcome of preg	nancy				23d Date of deliv	
Box 68760, e death certificate be ex the attending physician ed for use as the burial	Physician/Medic	23b. Was decedent pregnant in t past 12 months?	I LIVE	birth nant at time of de		etal death 3 other (Specify)	Ectopic preg	nancy	Month	Day Year
Box ne death the atte	hysi	1 Yes 2 No 9 V Ur	known 9 Unkr	nown		Aller (Opcony)				
P.O. Es that the d	by P	Part II. Other significant condi	tions contributing	to death but not re	esulting in the	underlying cause	e given in Part I.			to the cause of death?  Probably 4  Unknown
ords, P w requires t as been sign should be d	ted						<del>.</del>	- 24a. Was a		autopsy findings available
COTC law rec has be	Completed	<u> </u>						autop:	sy prior	to completion of cause of
ital Rec ician: The certificate rector, page		OF Man age affers discussion				26 Pla	ce of Death (Chec	1 Yes	2 No 1 🗸	Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death.  **I Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	Be	25. Was case referred to medical examiner?	Hospital: 1	Inpatient 2	ER/Outpatier	,	Othor:		Residence 6 🗸 O	ther: Scene
n of V ding Phy a. After th funeral c	2	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury th, Day,Year)	28b. Time of	Injury 28c. In	njury at Work?	28d. Describe h	now injury occurred	
ision Attendir r death. rector: A	Certification:		ding estigation			1	Yes 2 No			
ivis for At after of Direc	tific	3 Suicide 6 Cou	ald not be 28e. Pla	ce of Injury - At h	ome, farm, str	eet, factory, office	e building, etc.	28f. Location (S or Town, S		Rural Route Number, City
Divious after the point of the		4 Homicide	ermined (Specify			and at the time.	data and place of	and due to the source	o(a) and manner as a	tated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	Crieck only	aminer: On the basis	of examination a					e(s) and manner as s and place, and due to	
To with Con	Me	29b. Signature and title of certifi	and manner er	sialeu		29c. Lice	nse number		29d Date signed (	Month, Day, Year)
		anete				0.0	C.M.E.		March 26, 200	7
		30. Name and address of perso				Chrock D-V	mere MD 040	01		
		On Barrelland at the Barrelland	sistant Medical				nore, MD 212	U I		
St	tate	31. Date filed (Month, Day, Year		gistrar's Signati	L A.	ask)				

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ORIGINAL

			1 - For State Registrar	State of M	laryland		artmen rtificate					jiene eg. No.2 () ()	7		70
ľ	Physici		1. Decedent's Name (First, Middle, L Esther Lane Al								2. Date of Dea Month [arch 1.	Day Y	'ear	3. Time of 1:34	Death P M
)	/Medio		4a. Facility Name (If not institution, g	rive street and number	-)		4b. City,	Town, or	Location of			4c. County of	Death	1	
3.4		V _	Wilson Health (	Care Center	<b>:</b>				rsbur			Mont	gome	ery	
	Funeral Director		293-20-1282	. Sex 7. A 1 □ M 2 🔀 F	ge (In yrs. Ia		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day April 1	Year) 3,1925	Birthp Cour Oh1	nlace (State or ntry) O	Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside Cit	y Limits
	Many Hied	tor	Maryland Montg	omerv	Ga	aither	sburg							1 🔯 Yes	2 🗌 No
	th the	Funeral Director	10e. Street and Number				10f. Zip	Code				0g. Citizen of Wh	at Cour	itry?	
	ath wi	rai	333 Russell Ave					0877				USA			
	er de	une	11. Marital Status	12. Was Deceden Armed Forces 1 ☐ Yes 2 ₹	?	S. 13.	Was Deced If Yes, spec	tent of Hi of Cuba	ispanic Ori n, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- lican, etc.)	14. Race - Black,	Americ White,		
36	irs aft	by F	1 ☐ Never Married 2 ☐ Marned 3 【 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 □ Yes 2	2 <b>⅓</b> No	Specify:			Specify:	Wh	Lte	
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "natural" or Iteme 23a or 28e-1 show event, the Mudical Examinar must be notified at	ted	15. Decedent's			16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of Busi	ness/in	dustry	
218	within 7 ene. then "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or	5+)	lite.	kind of wor DO NOT us	nk done d se retired	turing mos	it of workin	g				
	e filed within at Hygiene. I other than '		12			Hor	nemak	er				Domest			
Maryland	ntai H od oti	Be	17. Father's Name (First, Middle, La	st)								Maiden Sumame)			
2	should be nd Mental marked o	<sup>L</sup>	Martin Dominic  19a. Informant's Name/Relationship	(Type, Print)		19h Mailir	na Address	(Street a		·		gelo Dom			
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic system.		Patricia A. Dicl									Village			36
Baltimore,	s 1 and 1 an		20a. Method of Disposition		0.0	ace of Dispo	sition (Nan	ne of		Da		20c. Location - C			
E	Page nent c int: If		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		3	t Have			1	3/20/2	2007	Hagerst	own	Mary1	Land
alti	apartn sports sports y inju		21. Signature of Funeral Service Lic	a y		11 11 11 11 11 11						Funeral			
<b>m</b>	207		I h	2		11	601 P	enns	ylvan	ila A	enue,	Hagersto	wn l	-	
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each	line.	aile	er the mode	d_	72 1				0	Approximate Interval Betwood Onset and D	eath .
68760,	ate be executed by sicien and he burial-transit	edical Examiner	d							nal					
P.O. Box (	that the death certific ed by the ettending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No								23d. Date of Month		*	ear .	
Vital Records, F	88 P. 90	۵	Part II. Other significant conditions	contributing to death	but not resul	iting in the u	nderlying ca	ause give	n in Part I.	•		bacco use contrib es 2 No 3		ne cause of de ably 4 □U	
00	law requiras been si 2 should l	Completed	Hyperter	ision.	Ex	oxh	age	te	e		24a. Was a	n 24b. We	re auto	psy findings a	vailable
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ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or				
	d o y	ျှ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 🗆 E	ROutpatien	t 3□ DO	A Othe	or: 4 🔟 Nu	ırsing Hom	e 5 ☐ Reside	ence 6 □Other	(Specif	1)	
n o	ding Ph J. After the funeral	inol in	27. Manney of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury		8c. Injury Work			3d. Describe h	w injury occurred			
Division of	al or Attending after death. I Director: After d in by the fune	Certification:	2 Accident Investigate 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Ir	njury - At hor ntc. (Specify)	me, farm, str	M 1 □ Yes 2 □ No  eet, factory, office 28f. Location (Street and Number or City or Town, State)			o <i>r Rura</i>	l Route Numb	er,			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying 8 (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examinati	vledge, death ion and/or in:	occurred a	at the tim in my op	e, date an pinion, dea	d place, ar	nd due to the c d at the time, d	ause(s) and mann ate and place, and	er as si	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		,	0			number	-		9d. Date signed (			
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14	4-25		30. Name and address of person wh	o completed cause of			Print)	d	61	1200	1822 1820	LAU LRG, N	2/	148	700
10/	Sta	te	31. Date filed (Month, Day, Year)		trar's Signati		ر <u>ب</u>	0	-1//	rre.	KN B	cico, in	VO	OXU B	1/
1	Registr	40000	31. Date filed (Month Day, Year) MAR 20	2007	haa	h. 1	الطام	)							

Division or Vital Records. P.O. Box 68760. Hospital or Attending Physician: To the Hospital of within 24 hours af To the Funeral D

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DHMH 17 Rev 1/2001

State Registrar

MBAOUR 31. Date filed (Month, Day, Year) MAR 20 2007

29b. Signature and title of certifier

MA 251

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Antietam

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D625 88

29d. Date signed (Month, Day, Year)

March 15th

			1 - For State Registrer	ite of Maryland /	-	artmen			and Me		- 1	TOOC	10172
			Decedent's Name (First, Middle, Last)				0, 2	Joann		2. Date of Dea	eg. No. th	- 001	3. Time of Death
	Physici /Medic		Clyde Mitchell A	bell						Month March	Day		
	Examir		4a. Facility Name (If not institution, give street			4b. City,	Town, or	Location o				County of Dea	
	*.		128 Thomas Jeffers	on St.		1	Plat					Charle	s
	Funeral Director		5. Social Security Number 6. Sex 1719-16-3085	7. Age (In yrs. last I	Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Nov . 28	Year)	9. Bi	rthplace (State or Foreign ountry) ryland
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Lo	cation							10d. Inside City Limits
	Mary -1 ehc	ţ	Maryland Charles	Lal	Plat	а							1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number			10f. Zip	Code		-	1	Og. Citi:	zen of What C	ountry?
	th wit		128 Thomas Jefferson	St.		20	0646				τ	J.S.A.	
	r dea	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S. ned Forces?	13.	Was Deced	ent of His	spanic Orig	in? (Spec	ify Yes or No- lican, etc.)		14. Race - Am Black, Whi	
36	s afte or It	by Fu	1 Never Married 2 Married 1	Yes 2 No es, Give		1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,				
8	hour	ed b	15. Decedent's Education	ar or Dates:	a Dece	dent's Usua	LOcorpos	tion				, , , , , , , , , , , , , , , , , , ,	hite
215	be filed within 72 hours after death with the Maryland ital Hygiene. In the maturel, or tems 23e or 28e-1 ehow event. The Medical Eracilizer mint be rediffical at	Completed	(Specify only highest grade comp	leted)	(Give	kind of wor DO NOT us	k done di	urina most	of working	g	IOD. KI	nd of Business	vindustry
21,	d with giene er the	E O	8	lege (1-4or 5+)	onti	rol R	Room	Ope	rato	or 1	J.S	. Gove	ernment
nd	be filed stal Hygid of other event.	Be (	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (	(First, Middle, I	Maiden	Sumame)	
yla	2 should be and Mental is marked creametic even	T <sub>o</sub>	Park Curtis Abell							elyn M			
Baltimore, Maryland 21215-0036	ges 1 and 2 should it of Health and Men If item 27 is marke or other treumetic	ŕ	19a. Informant's Name/Relationship (Type, Pri	gughter 19						Route Number			
آ	permit. Pages 1 and 2 Department of Health a Importent: If item 27 tis any injury or other tre	l ii	20a. Method of Disposition		of Dispo	NO1	ctna:	mpto	n Dr Da			ta, Mo	1. 20646
<u></u>	ages ant of it: If if		1 ☑Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)						ch 1	8,200	7		
Ē	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Licensee	Pali	22	Lll C	Address	of Facility	,			Annual Control of the	, Maryland
ä	Department		Vhatallin	M00668	V	Villi	ams	Fun	eral	Home			20640 ad, Md.
			23a. Part1. En er the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do	not ent	er the mode	of dying	, such as c	ardiac or	respiratory arre	est,	an nec	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DVANCE	01-	T1+1	5.1S	1.021	EX	1221			Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence									0
	- Adminior	_	Sequentially list conditions, b	ue to (or as a consequence		-4VI	1 m	4 DI	314	过,也			Y Y
	nsit	nlne	cause. Enter Underlying Cause (Disease or injury	de to (or as a consequence	90).		-	1					
Ć.	execu n and ial-tra	Examiner	that initiated events c.	ue to (or as a consequence	e of):								
8760,	cate be executed physician and the burial-transit	dlcal	d										
9	ng ph as t	Med	IF FEMALE:										5
Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant	es, outcome of pregnancy Live birth 2 🗌 Fetal deat	th 3 🗆	Ectopic pre	gnancy				2	3d. Date of de	
о О	the a	ysic	1 Yes 2 No 4L	Pregnant at time of death Unknown	5	Other (spe	ecity)					Month	Day Year
۵.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Ph.	Part II. Other significant conditions contributing	g to death but not resulting	in the ur	nderlying ca	use giver	in Part I.		23e. Did tob	acco us	se contribute to	the cause of death?
Records,	uires sign	d by		•		, ,				1 □ Ye		A	robably 4 🗀 Unknown
000	w require s been si should b	Completed								24a. Was ar	, 1	24h Ware a	utopsy findings available
_	The lay	mo								autops	/ led?	prior to death?	completion of cause of
Viital		BeC	25. Was case referred to medical					26. Place	of Death (	_1 □ Yes 2 Check only one	No (No	1 □ Yes	2 No
	hysic his ce I direc	To	examiner? 1 \( \text{Yes}  2 \( \text{Yo} \)  Hospital	1 ☐ Inpatient 2 ☐ ER/C	utpatien	3 DO	Other			5 Reside		Other (Spe	cify)
n	or Attending Physicien: The lifer death. Director: After this certificate he in by the funeral director, page		27. Manner of Death 28a.  1   Natural 5 □ Pending	Date of Injury (Month, Day Year) 28b.	Time of Injury	28	lc. Injury a Work?	at	28	d. Describe ho	w injury	occurred	
Sic	ttend death stor: /	Icat	2 Accident investigation 3 Suicide 6 Could not be	Dince of laive. At home of		M		es 2□N		f 1 (D)			
Division of	or Attendated after death	Certification;	4 Homicide determined 266.	Place of Injury - At home, f building, etc. (Specify)	arm, stre	et, factory,	office		28	City or Town	eet and State)	Nu <b>mber</b> or Hi	ıral Route Number,
	spite hours inerel y filled		29a. Certifier Certifying Physician:	To the best of my knowledg	ge, death	occurred a	t the time	, date and	place, an	d due to the ca	use(s) a	and manner as	stated.
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	Z Medical Examiner: On	the basis of examination a manner stated.	nd/or inv	estigation, i	in my opir	nion, death	occurred	at the time, da	te and	place, and due	to the cause(s)
	To 1 With To t	≨	29b. Signature and title of certifier	\ \ \		29c.	License	number		29	d. Date	signed (Monta	h, Day, Year)
}			FAMIN	JWM		1	1)	0 6	0 6	4	1	1/15	107
1	1815		30. Name and address of person who complete	cause of death (Item 23a)	(Type, F	Print)	0	600	n n	10%	00.	0 >	503
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature	10	IVI	1/	VYE		0121	1 . ((	4.0	, , , ,
	Registra		MAR 1 9 2007	Mercen K		hand !	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2007 РМ March 25 Merle Carrie Burnside 2210 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center E1kton Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, SEPT 1, 19 9. Birthplace (State or Foreign Country) West Virginia 1 ☐ M 2 👿 F 91 1915 232-02-8408 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 17 Enfield Road 21921 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2🏋 No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Rorrer Lessie Cantlev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy C. Barrow/Daughter 17 Enfield Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 28. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brookview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rising Sun. Maryland 21. Sign ture of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 علم 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CRITICAL AURTIC STENUSIS Due to (or as a consequence of): HTM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEVENE Demosia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes No 26. Place of Death | Check only one Other: 1 Inpatient

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

ir then "netural", or iteme 23a or 28a-f ehow The Madical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or iter any injury or other traumatic event, the Madical Examplina, once.

Baltimore, Maryland 21215-0036

death v

amlner and Il-transit attending physicien a for use as the burial been signed by the s should be detached director, After the funeral within 24 hours after death To the Funeral Director: , completely filled in by the f

To the Hospital or Attending Physician: The law requires that the death certificate be executed

death.

Division of Vital Records, P.O. Box 68760,

Medical Certifica

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15	Was case	referre	d to	med	lical
	examiner?			IIIaa	iicai
7.	Manner of	Death	_		

aminer?		-
☐Yes 2☐N	0	-
anner of Death		
Natural	5 Pending	

2 Accident 3 T Suicide 4 Homicide

investigation
6 ☐ Could not by
determin
1

			1 1 1	
	ertifier Check only * one)	Certifying 2 Medical	Physician: xaminer: On and	
29b. Si	onature and	title of certifier		-

Place of Injury - At home, farm building, etc. (Specify)

Date of Injury (Month, Day Year)

ıry	М	Work? 1 ☐ Yes	2 No
, stree	t, factory,		

factory,	office	

D54073

NEVUSTLE

28c. Injury at

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(smanner stated.						
	29c. License number	29d. Date signed (Month, Day, Year)				

DE

29d. Date signed (Month, Day, Year) 26 MAR 07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

			completed car	use of death (I	Item 23a)	(Type, P	rint)
ARUN	Store!	ins	817	Cituzin	RUS	C72	

31. Date filed (Month, Day, Year)

MAR 3 0



2007

State

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

		1	For State Registrar		aryland / Dep	artme	ent of I		-		200-	7 1017
Phy	sician		1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath Da	y Year	3. Time of Death
	edical	1	Raj Pal Bhanda						March	12	, 2007	4:30 P
Exa	miner		4a. Facility Name (If not institution, giv					or Location of Dea	th		. County of Dea	
· · · · · · · · · · · · · · · · · · ·	r-ecret		4515 Willard Ave.  5. Social Security Number 6. S		e (In yrs. last birthda)		Chevy der 1 Year	Chase If Under 24 Hrs	8. Date of Bir		Montgom	
Fune Direc				M 2□F	75 Yrs.	Monti		Hours Min		y, Year,	32 I	thplace (State or Foreig ountry) NDIA
/land ow		-	10a. State 10b. County		10c. City, Town or L	.ocation						10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show r must be notified at	ţ	į	Maryland   Montgom	ery	Chevy	. Cha	ise					1 X Yes 2 □ No
h the	Directo		10e. Street and Number				Zip Code			10g. Ci	tizen of What Co	ountry?
th wit	<u> </u>		4515 Willard Ave.	#807-S			208	815			INDI	A
ems ems	Fineral	5	11. Marital Status	12. Was Decedent 8 Armed Forces?	ever in U.S. 13	. Was De	cedent of I	Hispanic Origin? (S pan, Mexican, Pue	Specify Yes or No	)-	14. Race - Ame Black, Whi	
affer	ū		1 ☐ Never Married 2X Married	1 ☐ Yes 2 🛣 N If Yes, Give	lo		2 <b>X</b> No		to Thoun, etc.)		Specify:	ie, eic.
003 nours ural";	<u>\$</u>	2	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Specify:	Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other fraumafic event. the Medical Examiner must be notified at	Completed	2	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	(Giv	edent's U e kind of DO NO	sual Occu work done use retire	pation during most of wo d)	rking	16b. K	ind of Business	/Industry
d with	Ę		Elementary, cocondary (6 12)	5+	Me	chan	ical	Engineer	•	D.C	. Gover	nment
e file	Be	3	17. Father's Name (First, Middle, Last	)				18. Mother's Na	me (First, Middle	, Maider	Surname)	
/lar	P		Balwant Singh Bha	andari				Shakunt	:la una	vail	able	
ary			19a. Informant's Name/Relationship (	Type. Print)	19b. Mai	ing Addre	ess (Street	and Number or F	ural Route Numb	er, City	or Town, State,	Zip Code)
and and a salth		L	Maria del Carmen	Vega/Wife	4515	Will	ard A	Ave. #807	-S Chev	y Ch	ase,MD	20815
Baltimore, bermit. Pages 1 au Department of Hea mportant: If item any inlury or othe		1	20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐	Damoual from State	20b. Place of Disp cemetery, cre	osition (f	lame of or other pla	ce) Mar	chate 14,	20c. L	ocation - City or	Town, State
Pag Pag ment ant: I		J	4 □ Donation 5 □ Other (Specif		Metropol	itan	Crema	1 2	007	A1	ex., Vi	rginia
alt rmit. sparti porti	ouce.		21. Signature of Funeral Service Licer	isee O	2	22. Name	and Addre	ess of Facility De	Vol Fun	eral	Home	
m 82 = 8	P		* Kames Ch	9000	2	2222	Wisco	onsin Ave	., N.W.	Was	h., D.C	. 20007
Physicia /Medic Examin	al		23a Fax1. Enter the disease, or com- prince, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Metasta	the death. Do not er e. Atic Prost a consequence of):				c or respiratory a	rrest,		Approximate Interval Between Onset and Death 5 years
3760, ate be executed tysician and he burial-transit	cal Examiner		Sequentially list conditions, if any, leading to immediate course. Either United hing Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):							
68 tifficat g phy as the												
Records, P.O. Box 68 The law requires that the death certifica tte has been signed by the attending phy age 2 should be detached for use as in	Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	2 ☐ Fetal death 3	□Ectopic □ Other	pregnanc (specify) _	у			23d. Date of de Month	livery Day Year
Records, P he law requires that has been signed t ge 2 should be deta	d by Pi		Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying	g cause giv	en in Part I.	23e. Did t			o the cause of death? robably 4
COrd  w requir  been s  should	ete								24a. Was	an	24h Were au	utopsy findings available
The lav	Completed	-							autor perfo	osy rmed?	prior to death?	completion of cause of
			25. Was case referred to medical					00 Plans of Pa	1  Yes		1 □ Yes	2 □ No
	o Be		examiner?	Hospital:	nt 2 ER/Outpatie	nt 3□	Oth	or:	th Check only o			
on or ding Phys  After this funeral dii	5		27. Manner of Death	28a. Date of Injury	v 28b. Time o		28c. Inju	4 LI Nursing F	lome 5 N Resident			ecify)
on on or other th.  The transfer of tuneral transfer or other tran	ţi		1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	М		rƙ? Yes 2 ∐ No			.,	
LIVISION Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer	Certification:		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur building, etc.	ry - At home, farm, st . <i>(Specify)</i>	reet, fact	ory, office		28f. Location (S City or Tov	Street ar vn, State	nd Number or Ri	ural Route Number,
DIVISIC  To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the it	Medical (		one) 2 Medicai Exam	ysician: To the best on niner: On the basis of and manner stat	examination and/or i	th occurrences	ed at the ti on, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s date an	) and manner as d place, and due	s stated. e to the cause(s)
To the I within 2.	2	2	29b. Signature and title of certifier	4///	7	2	9c. Licens	e number		29d. Da	te signed (Mont	h, Day, Year)
5			* / Tret	L. W			D0060	129	M	ſarcl	h 13, 20	007
		3	30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print)						
			Brent K. Cole, M.			7e.,	#730	Chevy Cl	nase, MD	208	15-4447	
	State istrar	3	31. Date filed (Month, Day, Year)  MAR 1 6 20	3 Reģistra	r's Signature	ante	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Stella Marie Burley /Medical MARCH 13TH. 2007 19:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🖫 F 75 Director 09/07/1931 Pennsylvania 196-22-0476 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Director 1 X Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 220 Somerville Avenue, Ste. 711 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse's Aid 12 Hospital 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Joseph Mikrut Anna Cammon မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnna Shore / daughter 139 N. Lakewood Drive, Ridgeley, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Cumberland Crematory 03/15/2007 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, Calin 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RENAL FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORONARY ARTERY DISEASE Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetai death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABETES 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE HEART FAILURE certificate has autopsy perforr 1□ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only or 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D46346 March 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) na 625 SHAKIL, HUMA, M.D., KENT AVENUE, SUITE 204, CUMBERLAND, MD 21502 32 Registrar's Signature 31. Date filed (Month, Day, Year)
MAR 1 5 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Physician CHARLES FLWOOD BEAN 03 2007 06 2105 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 8. Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F 216-01-8783 94 Director Maryland October 18, 1912 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Honeysuckle Lane "natural", or items 23a or U.S.A 21532-Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 DYes 2 No 1944 — If Wes, Give Year or Dates: 195€ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 Nidowed 4 Divorced 1950 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bakery 12 should be filed w h and Mental Hygier 7 Is marked other th owner/operator permit. Pages 1 and 2 should be filed Department of Hoalth and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice Bean ပ Nellie Hershberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxann Haupt daughter 17609 Mount Savage Road Frostburg Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Maryland March 10, 2007 Frostburg Frostburg Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA about 3 day **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or conjug Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1( npatient ပ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier \*\*Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4/104

hky State

State Registrar DR. HARTH SID 31. Date filed (Month, Day, Year) MAR 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. HATIT SIGHU 935 BISHOP L

925 BIShop WAISH ROAD, Cumberland MD 21502

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			Please  1 - For State Registrar	State of M	aryland / Dep		Health and N			7 101	77		
6 6	Physic		1. Decedent's Name (First, Middle, L Thelma Ilene Bur			2. Date of De		3. Time of 6:20	of Death OPM				
	/Medi Examir		4a. Facility Name (If not institution, gi 332 Henry Avenue	ive street and number)		4b. City, Town, o	or Location of Death		4c. County of Death Washington				
14 / C	Funeral Director		5. Social Security Number 6. 220-54-3730 Usual Residence of Decedent	Sex 7. Ag 1 □ M 2X F	e (In yrs. last birthday 57 Yrs.	Months Days		8. Date of Bir (Month, Da 10/08/	th ay, Year) 1949	9. Birthplace (State of Country)	or Foreigr 7 <b>A</b>		
036	r 28s-f show	ctor	10a. State 10b. County MD Washin	gton	10c. City, Town or L Hage:	ocation rstown				10d. Inside C	City Limits		
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 332 Henry Avenue		10f. Zip Code 217	'40		10g. Citizen of Wh					
	after dea or Itams	by	11. Marital Status 1 □ Never Married ②☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecrfy Yes or No Rican, etc.)	Black	- American Indian, White, etc. Black			
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Maryland	should and Mer Is mark	To	Robert (unk) Har:	(Type, Print)			Mary Th	a <i>l R</i> oute Numb	er, City or Town, S				
	2 5 E G		Austin Burnett, 20a. Method of Disposition	Sr./Husband	20b. Place of Dispe	osition (Name of	venue, Ha	gerstow Date		/4() ity or Town, State			
Baltimore,	Light Services		1 ☑ Burial 2 ☐ Cremation 3 if 4 ☐ Donation 5 ☐ Other (Spec	ify)	Rose Hil	matory or other pla	ry 03/23	3/2007	Hagerst				
Bal	permit. Pa Departmer Important: any Injury		21. Signature of Funeral Service Lice	nsee		2. Name and Addre	etomac Str	ald N. eet. Ha	Minnich l	Funeral Ho MD 21740	ome O		
-112	Physician /Medical Examiner prize and prize transition and prize transit	a	23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  b. Due to (or as  c.	18.	(c/v_		or respiratory a	11651,	Approximat Interval Bet Onset and I	tween Death		
Box 68760,	es that the death certificate be exigned by the attending physicien be detached for use as the buria		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d23c. If yes, outcome	of pregnancy 2 □ Fetal death 3 [	⊒Ectopic pregnanc	у		23d. Date Mont		Year		
P.O.	at the de				1 Yes 2 No 9 Unknown	4□Pregnant at 9□ Unknown		Other (specify)				,	
	w requires the been signed should be d				Part II. Dther significant conditions	contributing to death b	ut not resulting in the u	Inderlying cause giv	ven in Part I.			ute to the cause of d	
of Vital Records,	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detache	Completed						24a. Was autor perfo 1 \( \text{Yes} \)	rmed2 dea	ere autopsy findings or to completion of ca ath? Yes 2 \( \text{No} \)	available ause of		
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Division o	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certification;	27. Manngr of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	00 - 01	28b. Time o Injury	M 1	rk?  Yes 2 □No		now injury occurred	or Rural Route Num	1000		
Div	pital or /		4 Homicide determined	building, etc	c. (Specity)		e d'Alaid	City or Tox	vn, State)				
	the Hos nin 24 hr the Fun npletely	Medical	one)	miner: On the basis of and manner sta	examination and/or in	vestigation, in my o	opinion, death occurr	ed at the time,	date and place, an	d due to the cause(s	;)		
	vith To	2	29b. Signature and title of certifier	1. Durlan	1 110	29c. Licens	4/1/7		29d. Date signed (	.07			
351	4-4		30. Name and address of person who Michael MC	completed cause of de	eath (Item 23a) (Type,	Print)	inpes !	Pajers	Lan	MO.			
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 20 2	2007 32. Registra	ar's Signature	med	,						

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 🗎 🗎 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 1 2 **Physician** /2007 Joseph E. Barrett 6:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bradford Oaks Nurs. & Rehab Ctr 7520 Surratts Road Prince Georges Clinton Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 579-12-4613 1**∑**M 2□F 87 07/19/1919 Wash., Director D.C Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location oriant: If item 27 ie marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at Md. Prince Georges 1 XYes 2 No Director Clinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7520 Surratts Road 20735 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or the any injury or other traumatic event, the Madical Examinations. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☒ No Specify: þ 3€Vidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baker Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dangerfield Barrett Mary O'Connor 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16245 Inheritance Drive Brandywine, MD 20613 19a. Informant's Name/Relationship (Type, Print) Elaine Hamilton (Daughter) Brandywine, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Washington Nat. 03/19/07 21. Signature of Feneral Service License 22. Name and Address of Facility Ralph Williams Funeral Service 1813 Potomac Ave., SE; Wash., 20003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Deman du /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 use as 10 the Funerel Director: After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 20 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 1 Inpatient 2 ER/Outpatient 3□ DQA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗆 No death. investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funerel I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certified B dress of person who completed cause of death (Item 23a) (Type, Print) 11701 Civingsta Year VAnna 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	larylar	•			lealth a Death			Reg. No.	1007	101	79	
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	Funeral Director		5. Social Security Number 6. 066-34-5853  Usual Residence of Decedent	Sex 7. A 1 ☑ M 2 ☐ F	ige (In yrs. 65	last birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di 4/5/41	th ay, Year)	Jac	othplace (State or Country) Cksonvil	le,Fl	
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DIVIS	를 를 들 c	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St.							Street and wn, State	d Number or F	Rural Route Numb	001,			
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State of Maryland / Department of Health and Mental Hygiene

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	/land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
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21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "netural", or items 23a or 28e-f ehow event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify: W	ite, etc.		
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Baltimore,	4 9 E 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, crer St. Mark	osition (Name of matory or other place s S Cemete	ery 3/20		20c. Location - City o			
Baltii	permit. Pages 1 Deportment of H Importent: if its any injury or ott		21. Signatur out, n ry Service Licens  Barbara A. Wi	. Wille.	mer 10	2. Name and Addres Ohn T. Wi	ss of Facility 11iams Fu	ineral He	ome swick, MD	21716		
	Physician /Medical Examiner	liner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CM SLS five heart failure.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						est,	Approximate Interval Between Onset and Death MON HU		
<ol> <li>Box 68760,</li> </ol>	The law requires that the death certificate be executed site has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Examine	that initiated events resulting in death) Last	Due to (or as a  d	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date ol d Month	elivery Day Year		
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rds	quires on sign uld be		Diabetes me	ellifus				1 🗆 Y	es 2 No 3 7	Probably 4 Dunknown		
Division of Vital Records,	The law requir	Completed						24a. Was a autops perform	sy prior to	autopsy findings available completion of cause of		
ital		BeC	25. Was case referred to medical				26. Place of Deal					
<b>&gt;</b>	Physicien: this certific ral director,	To E	examiner? 1 ☐ Yes 2' No		t 2 ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing Ho	ome 5 🗆 Reside	ence 6 Other (Sp	ecify)		
o uo	ing After une		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time o		28c. Injury at Work? 28d. Describe how injury or					
Divis		Certification	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)				28I. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in I	edical (	29a. Certifier 1 Check only one) 1 Medical Exami	Physician: To the best of my knowledge death occurred at the time: date and place, and due to the nature(s) and manner as stated aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	-		29c. Licens	e number	2	9d. Date signed (Moi	nth, Day, Year)		
)			▶ Kathleer W	Stern M	5	D3	32073		3/19/2	.007		
	10		30. Name and address of person who of Kathleen W St	en No	610 Nin		e, Brunsw	vick, Man	cyland 217	16		
	Sta Regist		31. Date liled (Month, Day, Year)  MAR 1 9 7	32. Registrar		porte						

			For State	State of Marylan		artment of F				2007	10181
			■ Registrar	1		lineate of	Dealli	2. Date of Dear	eg. No.	.001	3. Time of Death
	Physicia	ın	1. Decedent's Name (First, Middle, Last					Month March	Day	Year 2007	5:20 P M
>	/Medic Examin	100	John W. Breede 4a. Facility Name (If not institution, give	street and number)		,,,	r Location of Death			ounty of Death rederick	
		63	3886 Shadywoo			Jeffer		10 D . (D)			
	Funeral Director		5. Social Security Number 6. Security Number 211-16-5231	TM 2□F	last birthday) 1	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day) Dec 22	, Year)	Coun	lace (State or Foreign try) t Virginia
1	p.		Usual Residence of Decedent	100 0	y, Town or Lo	ocation				1	0d. Inside City Limits
	arylar show	۲	10a. State 10b. County		y, Town of Lo	Jefferso	nn.				1 ☐ Yes 2X No
	he M 28a-f otifie	Director	Maryland Frederi  10e. Street and Number	ck		10f. Zip Code	<u> </u>	T 1	IOa Citize	n of What Cour	ntry?
	with t		3886 Shadywood	Drive		21755	5			ed State	
	death ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	14	. Race - Americ Black, White,	
٥	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at		1 ☐ Never Married 2☐XMarried	Armed Forces?  1 XYes 2 No 194  If Yes, Give	4-	1 ☐ Yes Ž No		o nican, etc.)	1	pecify: Whi	
3-003p	hours ural", al Exa	d by	3 Widowed 4 Divorced	Year or Dates: 194		dent's Usual Occu	nation			of Business/Inc	
	in 72 In mat	Completed	15. Decedent's Ed (Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most of world)	rking			
717	filed within Hygiene. sther than "	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Gara	age Super	risor			Governm	ent 
and	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  Also Health and Mental Hygiene.  In the Z1 is marked other than "natural" or items 23a or 28a-f show it is marked other than "natural" or items Z1 is marked outer than "or other traumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)  . Tobe Breeden					ne <i>(First, Middle, .</i> 1 <b>Simmons</b>		urname)	
5	2 should be and Mental is marked craumatic ever	ဥ	19a. Informant's Name/Relationship (7	(ne Print)	19h Maili	na Address (Street	and Number or Ru	ural Route Numbe	r City or l	Town State Zin	(Code)
<u> </u>	and 2 sl ealth an n 27 is r er traur			Wife	1	,	ood Drive				,
စ	s 1 an f Heal item 2		Gloria Breeden / 20a. Method of Disposition	20b. I		osition (Name of matory or other pla		Date		ation - City or To	
saitimore,	permit. Pages 1 Department of H Important: If ite any Injury or of once.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State		Methodi	!	5/2007	Je	fferson	, Maryland
<u>=</u>	permit. Pag Department Important: I any Injury o		21. Signatura f Funeral Service Licen	900	2:	2. Name and Addre	ess of Facility St				
<u>n</u>	9 9 E E 9		1 outper	Tauffer			h Maple A			ck, MD	
		85 1	23a Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	ne cause off each line.			ing, such as cardia	c or respiratory an	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. RENAL  Due to (or as a consec		-010-	1.1				YEARS
	Examiner		Convention link conditions	Contract the Contract of the C	SCIE	20515					YEARS
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a somew	juante of;					Î	
	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consec	quence of):						
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ξ	tificate g phys as the	ledic		u		,					89
20X	eath certific attending p for use as	an/Iv	23b. was decedent pregnant	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic pregnanc	су		23	d. Date of delive	ery Day Year
O.	the att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of of 9☐Unknown	death 5	Other (specify)				WOTH	Day
7.	that the de ned by the a detached t		Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use	e contribute to t	he cause of death?
Vital Records,	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	d by	MEPHOTHER AD	ENOCAPEINOR	A OF	-THE E	80PHABU	J 15€	′es 2□	No 3 ☐ Prof	bably 4 □Unknown
<del>ဂ</del> ္ဂ	aw red s beer s shou	Completed						24a. Was a		24b. Were auto	ppsy findings available
ž	slcian: The law certificate has l irector, page 2 s	mo						autop perfoi 1∐ Yes	rmed? 2.2-No	death? 1 ☐ Yes	mpletion of cause of 2□ No
<u>Ta</u>	ian: ertifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or	ne)		
<u>o</u>	Physic this ce al dire	To	1 ☐ Yes 2 No		ER/Outpatie	III 3 DOA		lome 5 Resid			fy)
	ding Pi	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ıry at ork? ∃Yes 2∐No	28d. Describe h	ow injury	occurred	
Division	or Attending Physician: ifter death. Director: After this certifici in by the funeral director.	icat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of injury - At h	ome, farm, st					Number or Run	al Route Number,
2	al or A after I Dire	Certification:	4 Homicide determined	building, etc. (Spec	ify)			City or Tow	vn, State)		
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	edical C	(Check only Medical Exan	ysician: To the best of my kn niner: On the basis of examin	owledge, dea ation and/or in	th occurred at the investigation, in my	time, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) a date and p	and manner as solace, and due t	stated. to the cause(s)
	the l	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date	signed (Month,	Dav. Year)
	8487	_	> Monell.C	Connol 1	10		3/76/			13/67	
,	1/1/		30. Name and address of person who	completed cause of death (Ite							
	IV.		BRIAN M, C	CONNUR W			VENTH S	T. F/2	ese,	pick,	MD 21701
	Sta		31. Date filed (Month PyRYear) 9	2007 32. Pristrar's Sign	ature	back		/		/	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 9:00 Marguerite Elizabeth Brubacher March 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 40410 Breton Beach Road St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 3, 1919 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🗓 F Yrs. Director 215-70-7598 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40410 Breton Beach Road 20650 USa by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 8 Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clothilha Lee Abell Walter Aloysius Woodburn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Perigo / Daughter 40360 Breton Beach Road, Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 1 X Burial 2 □ Cremation 3 □ Removal from State Our Lady's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22, 2007 Leonardtown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acule Physician /Medical Due to (or as a consequence of) **Examiner** FIB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Due to (or as a consequence of) Examiner  $\mathcal{D}^{\mathcal{U}}$ or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page certificate 1□ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA မှ 1 🔲 Inpatient 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: After the funeral on the funeral process. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the time. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.D. SHAH, MD St. Mary's Medical Alert Building Leonardtown, MD 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Is fores Registrar MAR 1 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month March Physician Year 2007 9:26 A John Paul Bell, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Leonardtown St. Mary's 42525 Medleys Neck Road If Under 1 Year | If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2∏F 69 Yrs. Director 215-38-4290 Maryland April 7, 1937 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at Maryland St. Mary's Leonardtown 1 ☐ Yes 2x No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Medical Examiner must be re 42525 Medleys Neck Road 20650 IISA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2K No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paper Distributor Paper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Marie Woodburn is marked Paul A. Bell and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is a any Injury or other trans. Susan Bell Cousineau / Daughter 41930 Clover Hill Court Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State March 20 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland 2007 Our Lady's Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility of Funeral Servi Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6mm 140 /Medical Due to (or as a conse ence **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran that the death certificate be exect Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy TOL in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 □Unknown page 2 should Completed Was a autopsy performed? 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Chack only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day 27. Inner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Yes 2 No I or Attend after death. Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature a d title 29c. License number 29d. Date signed (Month, Day, Year) Daniel Howell, M.D. who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Hollywood, MD 20636

32. Registrar's Signature

24035 Three Notch Road

MAR 20

200

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month James Wayne Barnes 7:33 PM 2007 03 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Director 220-72-6674 42 11/19/1964 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "neturel", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified as 1 ☐ Yes 2 ☑ No Maryland St. Mary's Direct <u>Lexington Park</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20795 Willows Road 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black by 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1.2 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 11 Laborer Construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John Warren Barnes, Sr. ပ Mary Louise Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Alice C. Fenwick/Sister P.O. Box 1567 Lexington Park MD20653 20a. Method of Disposition 20b. Place of Disposition (Name of cometery crematory or other place)
Immaculate Heart
of Mary Church Cem. 20c. Location - City or Town, State Pages nent of h Deportment of Important: if it any njury or o 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/23/2007 Lexington Park, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronwy /Medical Due to (or as a consequence of): Examiner Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed ettending physicien and for use as the burial-transit Exami Due to (or as a conservence of): that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death Year P.O. 5 Other (specify) 1 ☐ Yes 2 ☐ No Ę 9 Unknown 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nhknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 24a. Was an autopsy performed? Yes 2 No certificete 1 Yes 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 X ER/Outpatient this 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury death. To the Hospital or Attend within 24 hours after death To the Funerel Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46351

State Registrar

Jeremy Tucker, D.O.

31. Date filed (Month

Vital

Division

ame

25500 Point Lookout Road, Leonardtown, MD 20650

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MARCH 0145 Thomas Baker 15 2007 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ENTER ALISBURY ICOMICO KEGIONA MEDICAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 € M 2 □ F Director 213-24-2545 78 10-4-1928 Maryland Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits show a or 28a-f show be notified at 1 ☐ Yes 2 No Director Sussex Frankford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 22225 Cypress Road 19945 Examiner must USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes ≥ □ No 1951— If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🖾 No þ Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Agriculture 6 Is marked other t of Health and Mental Hy fitem 27 Is marked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Baker Flora Watson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris C. Baker - wife 22225 Cypress Road, Frankford, DE 19945 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or otl 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pittsville Cemetery 3-20-2007 | Pittsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Functial Service Licenses 705 E. Main Street, Salisbury, MD 21804 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final colon Physician concer Mearrs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e esta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner certificate be executed and Due to (or as a consequence of): burial Box 68760, attending physician for use as the buria Physician/Medical the ast IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I ed by the a ☐ Yes 2☐ No 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probabiy 4 ☑Unknown 1 ☐ Yes Kinsons di Sea 80 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has le 2 autopsy page performe Diasetes certificate Division or Vital 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 After this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

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IVA

100 East Corroll st

32. Raistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jalak

Seyed A.

31. Date filed (Month, Day, Year)
MAR 1 9 2007

D0060715

Salisbury, MD 21804

March 15 2007

			1 - For State Registrar	State of Maryl		artment of H			jiene	7	101	86
	5 5		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dear	th Day	Year	3. Time of	Death
	Physici /Medio		Vi	rginia Elyse	Crouch			March	- ·	07	0230	A M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ith	4c. County			
F			Laurelwood Car			Elkton If Under 1 Year	If Under 24 Hrs	s. 8. Date of Birth	Cec		lace (State o	- Caraina
	Funeral Director		5. Social Security Number 6. So	DM 217 F 87	rs. last birthday) Yrs.	Months Days	Hours Min		, Year)	Coun	land	r roreign
	` ÷		212-30-5801 Usual Residence of Decedent					JAN 2J,	1920	Tial y	rand	
	how		10a. State 10b. County	10c.	City, Town or L	ocation				11	0d. Inside Ci	
	Ba-f	cto	Maryland Cecil		Elkton						1 🗌 Yes	2 X No
	or 28	Directo	10e. Street and Number			10f. Zip Code		1	Og. Citizen of V		-	
	s 23s	ral	2151 Blue Ball	Road  12. Was Decedent Ever i	- 11.5	Was Decedent of H		Sacatu Vac as Na	Unite	d Sta		
_	iten de	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces?	10.5.	If Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)		k, White,		
5	urs at	þ	3 ₩ Widowed 4 Divorced	If Yes, Give A Year or Dates:		1☐ Yes 2∏ No	Specify:		Specify	Whi	te	
215-0036	within 72 hours atter death with the Maryland ene. then "naturei", or items 23a or 28a-f ehow fra Medical Exercitar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra-		16a. Dece	dent's Usual Occupa	ation	orkina	16b. Kind of Bu			
7	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	9	<b>T</b>	0	**	
7	il Hygier other th	Cor	12		Но	omemaker	19 Mothods Na	ame (First, Middle, i	In Her		Home	
and	B a b	Be	17. Father's Name (First, Middle, Last)	:+h				Elizabet				
$\overline{\mathbf{x}}$	2 2 6 6	ဥ	Lewis Baily Sm		19b. Maili	ng Address (Street a					Code)	
Mar	and 2 sho saith and n 27 is m		Wilma M. Crouch/Da			nessa Ave						
ē,	s 1 ar		20a. Method of Disposition	20		osition (Name of matory or other place	The second secon	The second secon	20c. Location -			
Ê	Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval Hom State	Zion Cem		20		Cecilto	n M	arvlan	ıd
altimore,	permit. Pag Depertment important: t eny injury o		21. Signature of Funeral Service Licen						Δ	.,		
n	8 9 E 8 9		Widen Heck	Cresman	10 ر	2. Name and Addres LCks Home 03 W. Stoo	kton St	reet, Elk	ton, Ma	ryla:		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the cone cause on each line.	eath. Do not en	ter the mode of dyin	g, such as cardia	ac or respiratory arr	est,		Approximat Interval Bet Onset and I	ween
)	Physician		Immediate Cause (Final disease or condition	a. Reson	rator	1 000	- 40				Oriset and t	Jean 1
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):							
		Je.	Sequentially list conditions,	b. Due to for as a son	toguerine offic		Ug.					
Z.	uted f ansit	Examiner	Sequentially list conditions, if any, sading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cherry	فالدرا المحك	terry (	doea	10				
ĵ.	be executed sicien and burial-transit		resulting in death) Last	Die to (or as a con	sequince of):							
2/PU	certificate be executed iding physicien and use as the burial-transit	cal		d	.=1/							
٥	e as t	Med	IF FEMALE:									
X Q Q	ath or u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	Ectopic pregnancy			23d. Date Mor	e of delive nth	-	Year
	res thet the de signed by the e I be detached t	ysic	1 ☐ Yes 2 ZNo 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown	ordeath 5L	Other (specify)						
	thet t		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to th	e cause of d	leath?
SD	requires thet een signed b nould be deta	d by						1 X Y	es 2 🗆 No	3 Prob	ably 4 □l	Jnknown
ecord	> 0 0	Completed						24a. Was a	n 24b. V	Vere autor	osy findings npletion of c	available
Ľ	0 5 0	E O						autops perform	med? d	leath?		ause or
VITA	iician: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of De	eath (Check only on				
o   	Physician: r this certific ral director,	To	1 Yes 2 No		ER/Outpatie		4 Nursing	Home 5□Reside	ence 6 Othe	er (Specify	)	
<u></u>	iding Physician: h. : After this certification of tuneral director, i	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Worl		28d. Describe ho	ow injury occurre	be		
DIVISION	E a c	cat	2 Accident investigation 3 Suicide 6 Could not be	1	t home farm st		Yes 2 □No	28f. Location (Si	treet and Numbi	ar or Bura	l Route Num	ber
2	is Hospital or Attanding P 124 hours after death. In Funeral Director: After toletely filled in by the funeral	Certification:	4 Homicide determined	building, etc. (Sp	ecity)	reet, factory, office		City or Town		37		00.1
	spita nours nerai		29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge, deat	h occurred at the tin	ne, date and place	e, and due to the c	ause(s) and ma	nner as st	ated.	
	ths Ho hin 24 I the Fu mpletel	edical	(Check only 2 Medical Exemone)	iner: On the basis of exam and manner stated.	nination and/or in	vestigation, in my o	pinion, death occ	curred at the time, d	ate and place, a	ind due to	the cause(s	.)
	To the Hospital or Attuwithin 24 hours after de To the Funeral Directic completely filled in by the	M	29b. Signature and title of certifier	1.010		29c. License	e number	. (	9d. Date signed	(Month, I	Day, Year)	
}			1 Coloaypo	rullD,		Door	-60 to	0	5126	120	107	-
	5		30. Name and address of person who	completed cause of death (	Item 23a) (Type,	Print) 772 (	11 Mai	n St	Elk.	Lon	. Mi	>
		to	31. Date filed (Month, Day, Year)	Registrar's Si	gnature 1	100					( )	
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DHMH 17 Rev 1/2001

Registrar

			For State	State	of Marylar		artment of F		_	(5.7	of Sol was	1010
		-	Registrar  1. Decedent's Name (First, Midd	lo l not)					2. Date of De	Reg. No.		3. Time of Death
	Physici /Medic		MERCIE RUIZ		L				March	14, 200		10:37 A <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution	-				r Location of Deat	th		ty of Death	
		ap 4	Montgomery Ger 5. Social Security Number	neral Hosp	oital   7. Age (In yrs.	last hirthday	Olney If Under 1 Year	If Under 24 Hrs	8 Date of Bir		gomer	y place (State or Foreign
k	Funeral Director		584-52-8541	1 M 2 ∏ F	7. Age (iii yis.		Months Days	Hours Min		, 1954	Coui	
	m w		Usual Residence of Decedent  10a. State 10b. County	1	10c, Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	Maryla f sho ied at	JO.		gomery		ithers						1 ☐ Yes 2 No
	the l	Director	10e. Street and Number	gomery		Tellers	10f. Zip Code			10g. Citizen of	f What Cou	ntry?
	n with	al Di	19022 Quail Va	alley Blvd	l <b>.</b>		208	379		United	Stat	es
	deatl	Funeral	11. Marital Status	12. Was Der Armed F	cedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No		ace - Americ	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exam	by Fu	1 ☐ Never Married 2万 Mar 3 ☐ Widowed 4 ☐ Divorce	rried 1 ☐ Yes If Yes. G	2 <b>∑</b> No iive		1 Tes, specify Cub. 1 Types 2 □ No				eify: Wh	
9	2 hou atura cal E	ted t	15. Decede	nt's Education		16a. Dece	dent's Usual Occur	ation	and the second	16b. Kind of	Business/In	dustry
215	thin 7; e. an "n Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	) (1-4or 5+)		kind of work done DO NOT use retire	during most of wo d)	prking			
7	ed wil ygien ler th	Con			•	Home	Maker			Own		
Maryland 21215-0036	ntal H ed oth	Be	17. Father's Name (First, Middle						me (First, Middle les Gonz		ame)	
2	2 should and Mer is marke aumatic	은	Santiago Ruiz  19a. Informant's Name/Relation			19b. Maili	ng Address (Street				n, State, Zii	Code)
	nd 2 sho aith and 27 is m r traum		Theodore C. Ca		ısband)		2 Quail V			•		
re,	ss 1 ar		20a. Method of Disposition	• II n		Place of Dispo	osition (Name of matory or other place	-	Date 19,	20c. Location		
altimore,	Page nent c		1 🖾 Burial 2 □ Cremation 4 □ Donation 5 □ Other (		n State I .	1 Soul	s Cemeter	у 200	)7	German		Md.
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service	Licensee		1	2. Name and Addre	<sup>ss of Facility</sup> De er Park	eVol Fun Dr. Gai	eral Ho thersbu	me rg, M	d. 20877
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that	caused the dea	th. Do not en	ter the mode of dyli	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	-67	05/S							Onset and Death
1	/Medical		resulting in death)		o (or as a consec		4					
	Examiner	L	Sequentially list conditions,	b	1 4 > 1	ailur	e					
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	xecut and	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	quence of):					+	
8760,	icate be executed physician and s the burial-transit	dical E		d								
တ	tificat ng phy as the	ledi								1		
Š	leath certific attending p I for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/hths?	1 ☐ Live	utcome pf pregn birth 2 ☐ Fet	al death 3	⊒Ectopic pregnanc	y			Date of deliv	ery Day Year
Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Preg 9∐Unk	gnant at time of nown	death 5[	Other (specify) _					
ر. م	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
ğ	equire en sig ould b	ed b	Dicketes						1 🗆	Yes 2 10	3 ☐ Pro	bably 4 ∏Unknown
ecc	law renas ber	Completed							24a. Was	psy	prior to co	opsy findings available ompletion of cause of
<u>=</u>	: The cate it page	Con							perfi 1⊟ Yes	ormed? 2 No	death? 1 ☐ Yes	2 No
₹	sician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Hoonital			nt 3 DOA Oth	or.	eath (Check only			
ō	Phys rrthis eral di	5	1 Yes 2 No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatie	III OLI DON	4 Linuising	Home 5 ☐ Res 28d. Describe	idence 6 □0 how injury occi		fy)
lon	nding th. r: Afte e fune	tion	1  Natural 5  Pendi 2  Accident invest	ng (Ma igation	onth, Day Year)	Injury		k? Yes 2 □ No				
Division or	r Atte er dea recto by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined   20e. Plac	ce of injury - At h	nome, farm, st	reet, factory, office		28f. Location (	(Street and Nur own, State)	mber or Rur	al Route Number,
	italol rs afte ral Di	Cer		4								
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the Examiner: On the	ne best of my kn basis of examin Inner stated.	owledge, dea ation and/or in	th occurred at the tinvestigation, in my	me, date and plac opinion, death oc	ce, and due to the curred at the time	e cause(s) and i e, date and place	manner as : e, and due :	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifi		inter stated.		29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
	->-0		1 Clucker	sepus			139	793		March	151	2607
,			30. Name and address of perso	n who completed car			, Print)			· · · · · · · · · · · · · · · · · · ·		
(	ツ		Christopher =				tice Phil.	D Duin	e Olno	y, me	1) 20	0834
State Registrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature												

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

viariuela Crider		- For State Registrar	State of I	viaryiand		rtment o tificate o		and ivie	ental Hy		g No. 200	7 10189
Physiciar Modical Examin	"	1. Decedent's Name (F Man	irst, Middle,Last) uela Cride	er		-			2	2. Date of Death Month <b>March 16</b> ,		3. Time of Death 1113 hrs
		4a. Facility Name (if no Washington Co	_	et and number)	-		4b. City, Tov Hagers		on of Death		4c. County of D Washingto	
Funeral Director		5. Social Security Number 173 - 66-				st birthday)	If Under Months		nder 24Hrs. urs Min.	8. Date of Birt	` 1F	Birthplace (State or Foreign Country Germany
d now any e.	ľ	Usual Residence of De 10a. State 10b	County Frankli	in		Town or Loca						10d. Inside City Limits 1 X Yes 2 No
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	=	10e. Street and Numbe					10f. Zip Co		7268	10	g. Citizen of What USA	Country?
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Marhal Hygiens and the filed with file Maryland inti. If item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once	Lune	11. Marital Status  1 Never Married  3 Widowed	2 X Married 1 4 Divorced If Yes	s, Give Year		lf Y	as Decedent Yes, specify	Cuban, Mexi	can, Puerto F	cify Yes or No- Rican, etc.)	14. Race - A White, of Specify:	American Indian, Black, etc. White
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygies of the filed within the ment of Health and marked other than "natural", or other traumatic event, the Medical Examiner	Completed by	15. Decedent's Educa Elementary/Seconda	ation (Specify only hig	ates:		16a. Deceder during n	nt's Usual Oc nost of workin	cupation (Gi ig life. DO <b>N</b>	ve kind of wo	ork done ed)	16b. Kind of Busin	ness/Industry
21215-0036 uld be filed within 7 Mental Hygiena narked other than e event, the Medica	Re Com	17. Father's Name (Firs Gunter				Certi	fied n	18.Mot	her's Name (	First, Middle, M re Wald	Nursing Haiden Surname) Itraut	nome
AD 21 2 should h and Me 27 is man matic ev	] ۵	19a Informant's Name/ Kirby M.	Relationship (Type, F Crider, Ji	,	use					ro, PA	ber, City or Town, $17268$	State, Zip Code)
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 25; nanked of injury or other traumatic event, th		20a. Method of Disposi 1 X Burial 2 4 Donation 5	Cremation 3 X R	emoval from St	ate C	Place of Dispo rematory or o	ther place)	•		Date 23/07	20c. Location - Ci	
Baltir permit. 1 Departm Importa		21. Signature of Funera	al Service Licensee	uev.		22. 5	Name and Ad	road S	St. Wa	e-Bower ynesbor	sox Fune o, PA 17	ral Home, Inc 268
Physician /Medical Examiner		23a. Part . Enter the di failure. List only o Immediate Cause (Fina or condition resulting in	one cause on each lin al disease a <u>Hea</u>		o Injuries	s	the mode of o	dying, such a	as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Thomas .	ner	Sequentially list condit if any, leading to imme cause. Enter Underlyii	tions, b	to (or as a cons								-
ecuted and transit	al Examiner	(Disease or injury that events resulting in dea	Initiated C.	to (or as a cons	equence of	):						
OX 687 eath certific attending p		IF FEMALE: 23b. Was decedent prepast 12 months?	egnant in the	Sc. If yes, outco Live birth Pregnant at		2 F	etal death other (Specify		opic pregnan	псу	23d. Date of de Month	elivery Day Year
<b>—</b> 😅 🚉 📜 .	اھ	Part II. Other significa			h but not re	esulting in the	underlying c	ause given ir	Part I.		bacco use contribu	ite to the cause of death?  Probably 4 Unknown
Rec The icate page	Completed									24a. Was a autop: perfor 1 Yes 2	sy pric med? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
of Vital Recing Physician: The After this certificate uneral director, page	To Be	25. Was case referred examiner? 1 ✓ Yes 2	No Hospit	tal: 1 Inpati	ent 2 🗸	ER/Outpatier	nt 3 DO	Other		Home 5		Other:
sion of attending P death. After ctor: After		<ul> <li>27. Manner of Death</li> <li>1 Natural 5</li> <li>2 Accident</li> </ul>	Pending Investigation	28a. Date of Inj (Month, Day Mar 16, 2007	(ear)	28b. Time of 0930 hrs		c. Injury at W	✓ No F	Passenger a	now injury occurred auto auto collis	sion
ospi hou y fill	Certification	3 Suicide 6 4 Homicide 29a. Certifier	Could not be determined	28e. Place of I	ajor Road	d / Highwa	У		F	or Town, S Route 316 , W	tate) /aynesboro, PA	or Rural Route Number, City
To the H within 24 To the F complete	Medical	one) 2 Me	edical Examiner: On t and				ation, in my c	pinion, deatl	h occurred at		and place, and due	e to the cause(s)
	Σ	29b. Signature and title	Porthall !	no				icense numb	Jel		March 17, 20	(Month, Day, Year)
5H-10		30. Name and address Pamela E. So	uthall, MD As	sistant Med	lical Exa	miner 1	11 Penn S	Street, Ba	Itimore, M	D 21201		
Sta Registr	ite	31. Date filed (Month,	R 20 2007	32. Rigistr	ar's Signatu	s. So	uk					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a I per ME, C866, 04/12/07dhb Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 17, 2007 1:35 a<sup>M</sup> John Albert Combs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 81 Days 177 M 2□ F Yrs. Sept. 29, 1925Maryland Director 213-22-0338 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or Items 23a or 28a-f shov the Medical Exeminer must be notified at St. Inigoes 1 ☐ Yes 2 ☑ No MD \$t. Mary's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48581 Loblolly Lane 20684 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify: White 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Technician Automotive other of Health and Mental Hyg If Item 27 Is marked other or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Leonard Combs Martha Mary Thomas 19a. Informant's Name/Relationship (Type. Print)
Roslyn Monsees (Personal Rep.) | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 48581 P.O. Box 5, St. Inigoes, Maryland 20684 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Brinsfield-Echols Cre, 3-22-2007 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypentermon **Physician** /Medical Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed APPROVED BY MED burial-tran Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SISSANO massillany 3 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 2 No Hospital or Attending Physician: after death.

Director: After this certific

in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 XYes 2 160 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 0 28a. Date of Injury 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 02/26/2007 **Unknown**<sup>M</sup> 1 ☐ Yes 2 No Subject fell 2 XAccident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 ☐ Homicide 21585 Feabody St., Leonardtown Nursing Home filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. D60888' 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan, MD. Shanti Medical Center 26840 Point Lookout Rd. Leonardtown, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 2

0 2007

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Elles March 17, 1:23 p Robert Carlson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Calvert Chesapeake Beach 4400 Christianna Parran Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1**X** M 2□F 18, 1928 Wisconsin 396-24-1500 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Chesapeake Beach MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4400 Christianna Parran Road 20732 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: 1946~49 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced white 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government logistician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elles Elizabeth Ann Reitz Carlson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn F. Esterley, daughter P.O. Box 219, Chesapeake Beach, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Sunderland, MD All Saints Cemetery 03/22/2007 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or combications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lesastati Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 4 ☑ No 2 X No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

physician and the burial-transi

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page 2 s has

The law requires that the death certificate be executed

or Attending Physician:

nours after death.

neral Director: At filled in by the fu

24 hours a Hospital

within 2.

Medical

Division or Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

and 2 should be filed within 72 hours after death i tealth and Mental Hygiene. m 27 is marked other than "natural", or items 23s er traumatic event, the Medical Examiner must

Health a

or other Department of Heal Important: If item 2 any injury or other once.

Saltimore, Maryland 21215-0036

the

Director

by Funeral

Completed

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/Medical

Examiner Physician/Medical 2 Completed Be Certification: To

29b. Signature and title of certifier

1 ☐ Yes 2 No		Hospital	1 ☐ Inpatient 2 [	☐ER/Outpatient	3 🗆 [	OOA Othe	r: 4	☐ Nursing H	lome
2 ☐ Accident	5 □ Pending investigation	28a.	Date of Injury (Month, Day Year)	28b. Time of	М	28c. Injury Work	at ?	2 □ No	280
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - At building, etc. (Spec	nome, farm, stree	et, facto	ory, office			28f

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

5 Residence 6 □Other (Specify)

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Day. Year) 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20639

State Registrar

SOLOMONS IS/ Rd. N 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2007 ▶

			Please Type or Print in B				•		•	
			State of Maryland				Mental Hy	giene	0000	10102
÷	_		1 - State Registrar	Cer	rtificate of I	Death	2. Date of De	Reg. No.	2007	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Sponcello Rachel Carpenter				Month	Day		7:05A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	March		County of Deat	
). 	EXAMINIT	eı	Civista Medical Center		Lapla	ta			Charles	3
#) ·	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. In	- ' '	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da March	rth	O Diel	nplace (State or Foreign
	Director		577-86-0676 1 M 2 M F 87 Usual Residence of Decedent	Yrs.			March .	1/,	1920 Was	hington DC
	land ow			, Town or Lo	cation					10d. Inside City Limits
	Many a-f sh ified	tor	Maryland Charles		Waldorf					1 □Yes 2X□No
	or 28.	Oire	10e. Street and Number		10f. Zip Code			10g. Cit	izen of What Co	untry?
	ath w	Funeral Director	2000 T4 Amber Leaf Place	2 40		602			US 14. Race - Amer	rioan Indian
	er dev items ner m	une	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☑ No	5. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	Black, White	e, etc.
36	ırs aft al", or xaml	by F	3 X Widowed 4 □ Divorced   Year or Dates:		1 □ Yes XIXINo	Specify:			Specify:	Mhite
21215-0036	72 hou	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decer	dent's Usual Occup	nation	kina	16b. K	ind of Business/	Industry
21	ithin 7 ne. han "r Med	nple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done DO NOT use retired	d)	iung		•	
121	iled w tygier her th nt, the	S	12th  17. Father's Name (First, Middle, Last)	Hon	<u>nemaker</u>	18. Mother's Nan	ne (First Middle	Maiden	Own Hon	1e
and	d be f ental l red or	) Be	Allen S. Talbott				L. Mon		, , , , , , , , , , , , , , , , , , , ,	
Maryland	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	T <sub>0</sub>	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street				or Town, State, Z	Zip Code)
	and 2 salth a 1 27 is er trau		Gloria Pappas - Daughter		Old Washi		., Wald	orf,	MD 2060	)1
ore	es 1 a of He fitem				sition (Name of matory or other plac		Date		ocation - City or	
Ě	. Pag tment tant: I jury c		4 ☐ Donation 5 ☐ Other (Specify)		Memorial				dorf, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee M01246		2. Name and Addre untt Fune				Washingt MD 2060:	
No.	20200		23a. Part1. Enter the disease, or complications that caused the death						MD 2000.	Approximate
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	mila	motor .	lach	ana .			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of the consequen	uence f):	orange !	y was	U V I			
B	Examiner		Seguentially list conditions b.	only	artey o	Ascel				
	po ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Jence 0:	And	ma				
	e executed ian and urial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequ	uence of):	110	0/110				
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6876	The law requires that the death certificate be tee has been signed by the attending physicit agge 2 should be detached for use as the bu	Physician/Medical	d							
Box	h cert	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feta		∃Ectopic pregnanc	v			23d. Date of del	•
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Vital			25. Was case referred to medical			26, Place of Dea	1  Yes ath (Check only		1 □Yes	2□ No
_ <	ys dir	To Be	examiner? 1   Yes 2   Hospital: 1   Impatient 2	ER/Outpatier	nt 3 DOA Oth	ner'			6 □Other (Spe	cify)
n or	ng Ph fter th ineral		27. Manner Ceath 1	28b. Time o Injury	Wor	ry at rk?	28d. Describe	how inju	ry occurred	
sio	Attending r death. ector: After by the fune	catic	2 ☐ Accident investigation			]Yes 2□No	001	/011		IB . W
Division	or At after d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At hobididing, etc. (Specific	y)	reet, factory, office		City or To	(Street al own, State	na Number or Hi e)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my kno							
	e Hoo	Medical	(Check only one)  2 Medical Examiner: On the basis of examina and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifie		29c. Licens	se number		29d. Da	ate signed (Mont	h, Day, Year)
			MINS YUX		D-5	7708			1171	0)
1	NR 11		30. Name and address of person who completed cause of death (Item						//	
(	1)()([	te	Abbas Omais MD Cenna Medic 31. Date filed (Month, Day, Yea) 32. Raffistrar's Signa	ature		Post 0	Ifice	RD	Waldor	f,MD20602
	Sta Registr		31. Date filed (Month, Gax, Year) 32. Refistrar's Signal MAR 1 9 2007	K .	mark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For state Amend PI, PII, 25, perME, G868, 6/16/Or efficient of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5:55PM Hazel Ruth Carroll March 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1Vista Medical Center La Plota, MD Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director Nov. 17,1929 Maryland 216-30-4660 Usual Residence of Decedent 10a. State 10c. Cify, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ex miner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20662 U.S.A. 8740 Special Place 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes Give X Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give 75 Year or Dates: Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carrell, Huze (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Others Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemuel Lena H. Henson Carroll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 is 8740 Special Place, Nanjemoy, Md. 20662 Doris Barber Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
March 17,
Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licen 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Ente disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Hypertensive atherosclerolic cardiovascular disease Immediate Cause (Final disease or condition resulting in death) @spinaron **Physician** /Medical Due to (or as a consequence) FEDERATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and s the burial-transit certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.0. detached 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ nocarcinoma tndometsium 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed S/P Hysterectomy and teratoma removal this certificate or Vital 1□ Yes 2 No 25. Was case referred to medical examiner? Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? After 28d. Describe how injury occurred Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Livertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057999 0

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regilfrar's Signature

JARIWALA, MD 11637 Terrace Dr, Ste 103 Waldouf MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Gladys Schwab March 15. 2007 Driscoll. 12:11 Рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day Year) | Oct. 6, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕮 F 80 Washington, DC Yre 578-28-9433 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Edgewater 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3660 6th Avenue 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Homemaker Elementary/Secondary (0-12) College (1-4or 5+) In Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Schwab Harry Catherine Ellen Leahy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeremiah J. Driscell / Husband 3660 6th Avenue Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 03/19/2007 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland Lay 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART CONGBTIVE DITCHOM disease or condition resulting in death) Due to (or as a consequence of): ATED Y EML) CARDIOMYDPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death
9□Unknown Month Year Day 5 ☐ Other (specify) 1 Yes 2 Vo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes XXXXNo 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy MENITUS performe DIABETE 1 Yes 2XXNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

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Pages 1

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Item 27 other t

= 5 Department o important: If any Injury or once, Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division or Vital Records,

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death certificate be executed burial-tran physician the use as ed by the a been signe should be page certificate Physician: director this funeral After Attending s after dea.

Physician/Medical Examiner Completed by Medical Certification: To Be filled in by To the Hospital of within 24 hours at To the Funeral Completely filled is

HYPERTENSION

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number DUOS1437

PARKUMY

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ANNAPOLIS MD 2140)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDILA

WD

DALLY 181TOYC 31. Date filed (Month, Day, Year) State MAR 1 9 2007

(Check only

29b. Signature and title of certifier

AAMC 32. Registrar's Signature

Registrar

18

DHMH 17 Rev 1/2001

avoi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** Muriel Η. Diggs 03/ 13. 2007 11:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 638-26-5709 52 Director 12/29/1954 Liberia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at MD Montgomery Silver Spring 1 TXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. items 23a c 2956 Gracefield Rd. 20904 Liberia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 之 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2X Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Counselor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 Is marked c Richard Harvey Marianne Moore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vamplah L.Diggs/Husband Item 27 I 2956 Gracefield Rd.Silver Spring,MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It, any Injury or o once. 1 X Burial 2 □ Crema 3 ☐Removal from State Gates of Heaven 3/31/2007 Silver Spring 4 □ Donation 5 □ Øtgler (Specify) 22. Name and Address of Facility Taylor's Funeral Home 21. Signature of Fun 722 N.Capitol St.NW Washington, DC 20002 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. L e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician at the burial-t Division or Vital Records, P.O. Box 68760. Physician/Medical as ittending IF FEMALE JSN. 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 I Inknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 XNO or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this uneral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 12 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral C completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54378

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Yea MAR 1 9 200

Dr. Cheryl Aylesworth 2730 University Blvd. Silver Spring, MD

30. Name and address of per on who compliced cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day SRACE MAXINE ENGLE 8:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ROAD AVALE ALLEGAN 1006 CASH VALLE Il Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year Feb 5, 1916 9. Birthplace (State or Foreign 1 □ M 2 💢 F PA Director 160-54-1356 Usual Residence of Decedent the Maryland 10a. State 10b. County or 28a-f show 10c. City, Town or Location 10d. Inside City Limits MD Allegany Mt. Savage Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "naturel; or items 23a or other traumatic event, the Madical Evant parties to 13208 Barrelville Road NW 21545 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental should be James Walker ဥ Maggie (Mull) Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pages 1 and 2 s ment of Health an Robert Engle 127 National Highway Health Item 27 son LaVale MD 21502 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any injury or o 1 Kurial 2 Cremation 3 Removal from State St. Paul-Wilhelm Cemetery 3/27/2007 4 ☐ Donation 5 ☐ Other (Specify) Salisbury PΑ 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 0 108 Virginia Avenue: Cumberland, MD 21502 233- Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): physician 68760 99 Physician/Medical tha attending Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy jo in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by tha a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ cete has been signated to page 2 should be Completed 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has The autopsy performed of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No DIAUGHTERS HOME this 1 Inpatient 2 CN/Outpatient 3□ DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation Injury death. 1 Yes 2 No Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 28I. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner is stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month Da)

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DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

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	Discortant		1. Decedent's Name (First, Middle, La	ist)	<u>-</u>						2. Date of Dea	ath Day		ear	3. Time of Death
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			147 Sylmar Road  5. Social Security Number 6.		ige (In yrs. las	t hirthday)	K1:		Sun	24 Hrs.	8. Date of Birt	h	Ceci		ce (State or Foreign
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Baltimore,	00		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 [	☐Removal from Stat	20b. Plac	ce of Dispo netery, crer	sition (Name natory or oth	e of her place	9) M	arch	30,	20c. Lo	cation · Cit	ty or Tow	n, State
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			23a. Pert1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	ed the death.	Do not ent	er the mode	of dying	g, such as	cardiac c	or respiratory ar	rest,	, riai	I A	Approximate
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	/Medical Examiner		resulting in death)	Due to (or a	s a conseque		7								1
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8760,	# × 6	dical	•	d											
Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3	Ectopic pre					2	3d. Date o		ay Year
P.0.	that the de ned by the a detached f	yslc	1 Yes 2 No 9 Unknown	4∐Pregnant 9☐Unknown	at time of deal	tn 5L	Other (spe	city)							
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	29a. Certifier 1 ★ Certifying P (Check only one)	hysician: To the bes miner: On the basis and manner	st of my knowle of examination stated.	edge, death n and/or inv	occurred a vestigation, i	t the tim	e, date an sinion, dea	d place, a	and due to the ded at the time, d	cause(s) date and	and manne place, and	er as stated due to the	ed. ne cause(s)
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	20		30. Name and address of person who	completed cause of	death (Item 2	3a) (Type,	Print)	FII	1, +.	A	1 D = :	671			,
	Sta	ate	31. Date filed (Month, Day, Year)	Regis	trar's Signatur	1707/1	66	L 11	Clon	+	11/2/	161			ne cause(s) sy, Year) 2010 7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Carrie Lee Foutz March 18, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ravenwood Lutheran Village Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 6/5/1918 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 🗶 🕽 F WEST VIRGINIA 236-64-8411 88 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD WASHINGTON HAGERSTOWN X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 LUTHER DRIVE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifts DO NOT use retired) HOMEMAKER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important; If item 27 is marked other any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOMER H. WOODWARD ETHYL L. JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY WILLIAMS/DAUGHTER 6620 LOCUST WAY, ANNANDALE, VA 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □Removal from State SHEPHEROSTOWN, WV **ELMWOOD CEMETERY** 22, 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 ling Try. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Monu 34Cars /Medical Due to (or as a consequence of): Examiner Ngestyn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examine certificate be executed lune sician and burial-trans Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4N Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 K Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After I 5 ☐ Pending investigation 1/2 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled 160 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760. P.O. Records, or Vital Physician; e Hospital or Attending P 24 hours after death. e Funeral Director: After t Division within 24 hours a To the Funeral (

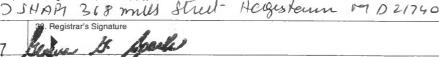
Maryland 21215-0036

Baltimore,

5

ANZAR 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D28365

29d. Date signed (Month, Day, Year)

3-14-07

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

enites

Year

1 ☐ Yes 2 X No

5:10 AM

Division or Vital Records, P.O. Box 68760

al or Attending F after death. I Director: After d in by the funera

3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat 2	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ce, and due to the cause(s) and manner as stated.  courred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier $\mathcal{M}_{*}\mathcal{D}_{*}$	29c. License number <b>70064560</b>	29d. Date signed (Month, Day, Year)  Mortch 11th, 2007

2 □ No

MEDICAL CENTER DRIVE POCKULLE, MO 20850

State Registrar

Medical

31. Date filed (Month, Day, Year)

WIDHI

NIKHONJ , M.D. MAR 1 6 2007

Name and address of person who completed cause of death (Item 23a) (Type, Print

			1 - For Stata Registrar	State of Ma	arylan				lealth a Death	and M		giene Reg. No.		7	102	00
	Dhuaia		1. Decedent's Name (First, Middle, La	st)						-	2. Date of De.			021	3. Time of	Death
	Physic /Medi		Eleanor	Langley		Fo	oster				March	14,	200	57	9:15	А. м
	Exami		4a. Facility Name (If not institution, giv 6410 Old Sandy S		d			r Town, or Jrel	Location of	of Death			County of		orge's	S
	Funeral Director		370-20-4177	Sex 7. Age	e (In yrs. 8	last birthday) 4 Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bird Aug. 2,	1922	W.	Birthpl Count ashi	ace (State o lry) Ington	r Foreign , DC
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Queen A	nne's		y, Town or Lo Vensvi								10	)d. Inside Ci	'
	with the	Director	10e. Street and Number 321 William Way				10f. Z	p Code 2166	6			•	zen of Wha		,	•
936	d within 72 hours after deeth with the Maryland Jiene. I then "neturel", or iteme 23a or 28a-1 show the Myzlical Examinar must be notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 Yes, Give Year or Dates:		1	Was Deci f Yes, spi 1 Yes	edent of Hi		gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)		14. Race - Black, V	America White, e	an Indian,	
Maryland 21215-0036	e filed within 72 housely Hygiene. I other then "neture vent, the Mydical E	ompleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (9-12)	ducation ide completed) College (1-4or 5	+)	16a. Deced (Give life. U	kind of w DO NOT i	ork done d use retired	ation furing most	t of workir	ng		nd of Busin		estry .fe In	s. Co
land 2	al Hyg	To Be C	17. Father's Name (First, Middle, Last, Harry K.	)		Lang			18. Mothe Nelda		(First, Middle,				Кеорр	
	as 1 and 2 should to Mealth and Ment Health and Ment Hear 27 is marked to the traumatic of		19a. Informant's Name/Relationship ( Lawrence Foster -	** *							Ville,					
Baltimore,	Pages 1 and the total total terminate of the market of the		20a. Method of Disposition  1 ②Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification)		C	lace of Dispo emetery, crem ct Line	natory or	other place	tery		/2007		cation - Cit	•	<sub>vn, State</sub> Jaryla:	nd
Balti	permit. Pages Department of I Important: If Its any injury or o once.		21. Signature Funda Service Light	nsee	Las	B <del>2</del>	erence 1 004	owde:	Bofgw r Mil	ardt 1 Roa	Funera ad Belt	l Ho svil	me,P.	A. Mary	land 2	 20705
8760,	hysician and purished state be executed physician and purished states in the buriar-transit	dicai Examiner	23a. Part. Enter the disease, or com shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each lin	e. ary / a consequ	Artery Jence of):			g, such as	cardiac o	r respiratory ar	rest,		у	Approximate Interval Berty Onset and E (CATS	ween
P.O. Box 687	The law requires that the death certificate be executed the been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 eyonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic p	pregnancy				2	3d. Date of Month		,	/ear
rds, P.	quires that n signed by uld be deta	d by Ph	Parl II. Other significant conditions of Hypertension; Dem		t not resu	Ilting in the ur	nderlying	cause give	on in Part I.		İ	bacco u		te to the	cause of do	eath? Inknown
Division of Vital Records,		Complete	Marie 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 - 1200 -								24a. Was autop perfor 1 Yes	SV	prior	r to com th?	sy findings a pletion of ca 2 \( \text{No} \)	available ause of
<u> </u>	itclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				1 01			Check only o					
on of	ling Phys After this Juneral dii	ion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	v	ER/Outpatien 28b. Time of Injury		28c. Injury Work	at ?	2	ne 5 Resid			<b>A.S.</b> 5.	isted	Lvg.
Division	To the Hospital or Attending Physician: whin 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined		ry - At ho . (Specify	me, farm, stre	M eet, factor		∕es 2 □ N		8f. Location (S City or Tow		l Number o	or Rural	Route Numi	ber,
	To the Hospital within 24 hours a To the Funerel I completely filled	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on the basis of and manner state	examınat	vledge, death ion and/or inv	occurred estigation	at the tim	e, date and inion, deat	d place, a	nd due to the o	ause(s) late and	and manne place, and	or as sta	ted. the cause(s)	1
)	To 11	W	29b. Signature and title of certifier	or of or	>		29	c. License D231			1		signed (M			
			30. Name and address of person who Rajkumar Bhojraj,					10 B	laden	sburg	g, Mary	land	2071	.0		
2	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 20	07 32 Registra	r's Signat	ure	all s									

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760,

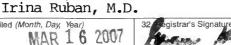
Baltimore, Maryland 21215-0036

within 24 hor To the Fune completely f the 2

> State Registrar

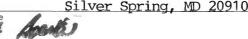
31. Date filed (Month, Day, Year) MAR 16 200

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D0063343

1500 Forest Glen Road

29d. Date signed (Month, Day, Year)

March 2, 2007

Registrar DHMH 17 Rev 1/2001

State

29b. Signature apd

le of c

31. Date filed (Month, Day, Year) MAR 2 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANOJ PANWALA MD 37767 MARKET DRIVE CHARLOTTE HALL Md 20622

32. gistrar's Signature

29d. Date signed (Month, Day, Year) 03-18-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 23, THEODORE DONALD HOOPES March 2007 3:39 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Bel Center Air Birthplace (State or Foreign Country) 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours Min 1 M 2 □ F 12/25/1949 204-40-9085 Director Pennsylvania Usual Residence of Decedent the Maryland r 28a-f show notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Harford Jarrettsville MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be 3158 Rocks Chrome Hill Road 21084 United States must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Deves 2 □ No If Yes, Give Year or Date 1 e tna M 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White "natural". the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Chemist Technician Nuclear Electric Item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be Kirkwood Robert Hoopes Audrey Romaine 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Judy K. Hoopes/Wife 3158 Rocks Chrome Hill Rd. Jarrettsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo Important: If It any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State William Watters Cem. 3/27/2007 Jarrettsville, MD. 4 Donation 5 Dother (Specify) 21. Signature of Funeral & Rice Lichisee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ECTRO MECHANICAL DISSOCIATION **Physician** resulting in death) /Medical Examiner Allung SECONDARY TO ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examine ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): GNICGIHALOPATHO IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P M.A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 DNUSHA SIRITHARA, 260 GDTEWAY DRIVE, SUITEDI,

Registrar

31. Date filed (Month, Day, Year)
MAR 3 0 2007

. Registrar's Signature

23

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year March 24, 2007 ELIZABETH CATHERINE HOLT 7:25 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Beverly Living Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Jan - L, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1 ☐ M **X2X** F 1907 217-48-8437 100 LaVale, MD Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany LaVale 1 □Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12103 Winchester Road 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🍎 No Specify: Specify: White 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Martz Annie (Metzner) Martz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Holt 12103 Winchester Rd., LaVale, MD Son 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SS Peter & Paul Cem | Mar 27, 2007 Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hafer Funeral Service, 1302 National Hwy., LaVale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 yrs. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 Is marked other tha any injury or other traumatic event, the Jones.

**Physician** 

**Examiner** 

**Funeral** 

**Director** 

show

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

<u>^</u>

Completed

Be

The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending physician for use as the buria the ģ Fo the Hospital or Attending Physician:

Examiner Physician/Medical þ Completed certificate director, Be ( Certification: To After 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

					10103 27	THO S PROBABILY 4 CONKINGWI
					24a. Was an autopsy performed? 1  Yes 2  No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?			26.	Place of Deat	h Check onl one	
1 Yes 2 Yo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4	Nursing Ho	me 5 ☐ Residence 6	□Other (Specify)
27. Manner of Death  Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci		ctory, office		28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	rsician: To the best of my kno					and manner as stated.

Medical

1ER State Registrar

29b. Signature and title of certifie

10000 2. Registrar's Signature

and manner stated

30. Name and address of person-who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Dav. Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** March 9, PHYLLIS CALHOUN HADLEY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rebecca House Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 🗓 F Yrs. **Director** 123-12-9971 93 Feb. 5, 1914 New Jersey Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at Directo Maryland Montgomery Potomac 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9910 River Road 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☒☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Bank Teller other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Ear1 Jonathan Hadley Disbrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Hadley, niece 263 Gundry Drive, Falls Church, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 Donatigh 5 □ Other (Specify) Fairfax Crematory Mar. 14, 2007 Fairfax, Virginia 22. Name and Address of Facility Everly Funeral Home 21. Signature of Funeral Service License 10565 Main Street, Fairfax, VA 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine sician and burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy as been signed by the atte 2 should be detached for in the past 12 months? 1☐ Yes 2☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy page performed? certificate 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work?

3. Time of Death

11:15 P

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

march 13, 2007

Year

1 ☐ Yes 2 No

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams, D.O., 6001 Muncaster Mill Road, Derwood, MD 31. Date filed (Month, Day, Year)

MAR 1 6

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

egistrar's Signature

and manner stated.

m Milliams

1 ☐ Yes 2 ☐ No

40058032

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

			State of Maryland / Department of Health a  1- State Registrar  Certificate of Death			7 1111 1	10207
			Registrar  1. Decedent's Name (First, Middle, Last)		Date of Death	. No.	3. Time of Death
ı	Physici /Medic		John Douglas Hengst		Month 3	14 2007	7:20 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  WMHS-Braddock Campus  4b. City, Town, or Location or  Cumberla	1		4c. County of Deat Allegar	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 F 50 Yrs. Months Days Hours	24 Hrs. 8	Date of Birth (Month, Day, Y 2-20-	9 Birt	hplace (State or Foreign untry)
	p		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Manyla Illed at	tor	PA Bedford Hyndman				1 ☐ Yes 2 🛣 No
	ier death with the Maryland items 23a or 28a-f ehow ner meat be collified at	Funeral Director	100. Street and Number 106. Street and Number 106. Zip Code 1554	45	10g	Citizen of What Co	untry?
	death ms 23	nera	11 Marital Status 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Orio		Yes or No-	14. Race - Ame	
36	s af	by Fur	Armed Forces?  1 Never Married 2 Married  1 Yes 2 Mo  1 Yes, specify Cuban, Mexican, 1 Yes, Sive  1 Yes 7 Order  1 Yes 2 No Specify:		an, etc.)	Specify:	o, etc.
5-0036	72 hours "natural",		15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	et of working	16	b. Kind of Business/	Industry
121	be filed within 72 hour ital Hygiene. d other then "neturel' event, ILe Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	n or woming	1	Manufact	turing
1d 2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)  18. Mother	er's Name (F	irst, Middle, Ma		1011119
Maryland		To B	Clarence William Hengst St. Hil	da	Belva	Burk	<del></del>
_	nd 2 suith ar 27 is		19a. Informant's Name/Relationship (Type, Print)  Jeanne A. Hengst/wife 1108 Gooseberr			O 4 .	5545
more,	000 ===		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		c. Location - City or	
altim			4 Donation 5 Other (Specify) Hynoman Cemetery  21. Signature of Funeral Service Licensee 22. Name and Address of Facility	3-17-	2007 H	ryndmai	n PA
Ba	permit. Departimport Import any inj		Justing N. Tertin Home 169 Clare	ence s	St. Hund	man PA	15545
			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cerdiac or re	espiratory arrest	t,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. MetaStafic AlUdei	nal	(a	ncer	3 mall
	Examiner		Due to (or as a consequence of)				Zweek
	D 15	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
_^	execute and al-trans	Examiner	Cause (Disease or injury that initiated events c				
8760	cate be executed obysicien and the burial-transit	dical	d.				
9	eath certifica attending ph I for use as t	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			004 0-4-44	
Box	death of atten	Physician/Me	1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?  1 Yes 2 No. ! 4 Pregnant at time of death 5 Other (specify)			23d. Date of del Month	Day Year
0.	at the de d by the a	Phys	9 Unknown  Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		03a Did tahar		the cause of death?
Records,	The law requires that the death certific Ne has been signed by the attending p page 2 should be detached for use as	ed by	Part II. Duties argument Continuous contributing to death out not resulting in the underlying cause given in Part I.		1 ☐ Yes		× .
eco	e law require has been si je 2 should t	Completed			24a. Was an autopsy	24b. Were au	topsy findings available
					performe	d? death? 2No 1 ☐ Yes	completion of cause of 2□ No
Vital	nysician: Th ns certificete i director, pag	To Be	examiner?		heck only one)	ce 6 □Other (Spec	7.6.1
Division of	ding Phy h. After this funeral c		27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year) Injury Work?		. Describe how		any)
Sio	Attendi death. ctor: A y the fu	catl	2 Accident investigation M 1 Yes 2 N 3 Suicide 6 Could not be		Location (Street	et and Number or Ru	ural Pouto Numbor
<u>≥</u>	ai or At s after d ii Direct ed in by	Certification:	4 Homicide determined building, etc. (Specify)	2011	City or Town,		ina riodie realiber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and a complete one of the complete of the complete one of the comple	nd place, and ath occurred a	due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number		29d	. Date signed (Monti	n, Day, Year)
	6		D6047	18	0	3/16/	0.7
	nas		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  About Ahmad M. D. 625 Kent Airenue Cum  31. Date files (Month, Day, Year)  32 Registrar's Signature	mhnu	land	Marilan	1-21817
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	IVUCT	way	was ysan	JANGUA
	Registr	ar	MAR 1 6 2001 2000 St. Brooke				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma			irtment of H tificate of L			giene Reg. No.	007	102	0.8
	Physicia	n l	1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	ath Day	Year	3. Time of	
	/Medic		Virgin		e	Не	elmick		03	15	07	1615	М
	Examin	er	4a. Facility Name (If not institution, giv	,				Location of Death			unty of Deat	h	
120		·	WMHS Braddock C  5. Social Security Number 6. S		e (In yrs. last birt	thday)		rland If Under 24 Hrs.	8. Date of Birt	th	egany	nplace (State o	r Foreian
	Funeral Director		218-24-8309		_	Yrs.	Months Days	Hours Min.	(Month, Da 10/03/	y, Year) 1928	Co	yland	- r oreign
	yland Iow at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Loc	cation					10d. Inside Ci	ty Limits
	a-f sh	ţō	MD Alle	egany		F1	intstone					1 ☐ Yes	2 No
	a or 28	Il Director	10e. Street and Number 12904 Murley's	Branch Ro	ad, NE		10f. Zip Code	21530		10g. Citizen	of What Co JSA	untry?	
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give		1	Vas Decedent of H f Yes, specify Cuba I □ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Ame Black, White ecify:	e, etc.	
21215-0036	'2 hours natural'; ical Exa	ted by	3 🕅 Widowed 4 □ Divorced  15. Decedent's E (Specify only highest gr.	Year or Dates:	16a.	Deced	lent's Usual Occup	ation	dna		of Business/	White Industry	
121	within 7 ene. than "r he Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5			kind of work done of the contract of the contr		ung	Gra	ocery	Store	
0	filed Hyg other ent, t	Ö	17. Father's Name (First, Middle, Last	t)				18. Mother's Nam	e (First, Middle,			20010	
Maryland	ould be Menta larked atlc ev	To Be	Harry	Verdeen	Ben			Nina			errin		
, Mar	and 2 sh salth and 1 27 is m er traum		19a. Informant's Name/Relationship Linda Smith / da				g Address (Street a			Flint	stone	, MD 21	530
nore	ages 1 sent of He int: If item		20a. Method of Disposition 1   3 Eurial 2 □ Cremation 3 European 2 □ Other (Special Content of the Content of		cemeter	ry, cren	sition (Name of matory or other plac emorial F	e)	Date 9/2007		ion - City or 1tston		
Baltimore,	Departmit. F Departmit Importar any Injui	1	21. Signature of Fureral Service Lice			22	Name and Address	ss of Facility Ad	ams Fam	ily Fu		Nome, 21502	P.A.
	E 77.71		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused y one cause on each li-	the death. Do n				<u> </u>			Approximat Interval Bet	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Meta	a consequence		eno Carc	inone of	l Colm			Onset and I	
	Examiner	L	Sequentially list conditions,	b	` `								
	outed ansit	Examiner	Sequentially list conditions, if any, leading to instructional cause. Enter Underlying Cause (Disease or injury that initiated events	c.	a consequence	oty							
68760,	ficate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as	a consequence	of):							
687	ficate phys s the	edical		_d									
Вох	ath certi ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		∃Ectopic pregnancy ∃ Other <i>(specify)</i>	,		23d	. Date of de Month	,	Year
P.O.	- 00		Part II. Other significant conditions	contributing to death b	out not resulting in	n the ur	nderlying cause giv	en in Part I.	23e. Did 1	tobacco use	contribute to	the cause of	death?
rds	w requires that s neen signed by should be deta	ed by							1 🗆	Yes 2	No 3□P	robably 4 □	Unknown
or Vital Records,	has h	Completed							24a. Was auto perfo 1□ Yes		24b. Were au prior to death? 1 ∐ Yes	utopsy findings completion of c 2 □ No	available ause of
ita	sician: The certificate rector, pag	Be C	25. Was case referred to medical					26. Place of Dea					
r V	Physician: this certific ral director,	To E	examiner? 1 ☐ Yes 2. ☐No		ent 2 ☐ ER/Ou	utpatien	nt 3□ DOA Oth	er: 4 🗆 Nursing H	ome 5 ☐ Resi	idence 6	Other (Spe	cify)	
o uo	ding Ph h. After th funeral		27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ary Year) 28b.	Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe	how injury o	ccurred		
Division	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the funeral difference of the function of the funeral difference of the function o	Certification:	3 Suicide 6 Could not I 4 Homicide determined	4   Zoe, Place of Inj	(ury - At home, fa tc. <i>(Specify)</i>	arm, str	reet, factory, office		28f. Location ( City or To	Street and Nown, State)	lumber or R	ural Route Nun	nber,
-	e Hospita 24 hours • Funeral etely filled	Medical C		Physician: To the best aminer: On the basis of and manner st	of examination ar								s)
	To the Vithin To the	Me	29b. Signature and title of certifier	DA			29c. Licens	_				th, Day, Year)	
	4			Topolon	-		print) Kent i	33580		Ma	roh	15 2a	70
	-		30. Name and address of person who	completed cause of c	death (Item 23a)	(Type,	Print)	2	0	i	, ,	11.	
	MAS		31. Date filed (Month, Day, Year)	ta MI	rar's Signature	2	Kent 1	TVENUE	Cun	ber	land	Maryle	and 21st
	Sta Regist		MAD 1 6 200	10.5	o digitaturo	han	No. 2						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Margaret Marilynn Harris М March 11 , 2007 2130 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/14/1933 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months 212-36-2070 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Cumberland Allegany 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 555 Arnett Terrace 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No 1 ☐ Yes 2 🗓 No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick (NMN) Morrison Marilynn Margaret Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Harris / husband 555 Arnett Terrace, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Vet. Cem. @ Rocky Gap 03/15/2007 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Fundal Service Licensee 404 Decatur Street, Cumberland, MD rece 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Massive Heart Attack Due to (or as a consequence of): Left Anterior Descending Artery Dissection Due to to las a consequence of Due to (or as a consequence of): If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner

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page 2 s certificate has

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Director: filled in by the

nin 24 hours after death. the Funeral Director: A

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Hospital

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Completed

Medical

physician

death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show la or 28a-f sh t be notifled a

23a

or items

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traumatic event, the Medical Examiner

with

death v

72 hours after

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Pages 1 and 2 should be

and Mental Hygie is marked other

Department of Health ar Important: If Item 27 is any Injury or other trau

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FFMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🖾 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ro Be	25. Was case referre examiner? 1 ☐ Yes 2 ☒ N	
Certification: To	27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pendir investi 6 Could detern

one)

5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ∏ Yes 2 ∏ No

29a. Certifier (Check only

💢 Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) anner stated

29b. Signature and title of certifier

29c. License number D0056355 29d. Date signed (Month, Day, Year) March 12, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

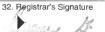
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 902 Seton Drive, Suite 204, Cumberland, MD Mark G. Nelson, 31. Date filed (Month, Day, Year)

nd State Registrar

5 TT

2007



Amend Item 23a per dr. g866,04/26/07dhb.

State of Maryland / Department of Health and Mental Hygiene 1- State of Maryla State of Maryla Registrar WCHD/SH 3/21/07 per FH Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 17, Day 2007 ear **Physician** 0655 VERNON HARVEY HOUSER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WASHINGTON **HAGERSTOWN** JULIA MANOR HEALTHCARE CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Juniorth, gay, Year) 916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 □ M 2 □ F 90 214-16-7254 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 Yes 2 No **HAGERSTOWN** MARYLAND WASHINGTON Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 333 MILL STREET 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 WYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 👿 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WOODWORKER FURNITURE MANUFACTURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HARVEY WILLIAM HOUSER MARY BELLE DAUGHERTY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUE E. KERSHNER, DAUGHTER 121 FAIRGROUND AVENUE, HAGERSTOWN, MARYLAND 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 vurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) BOONSBORO CEMETERY 13/21/2007 BOONSBORO, MARYLAND 21. Signature of F ral envice Licensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal failure Years Due to (or as a consequence of): Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2/2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide

Examiner certificate be executed burial-transit and Box 68760 attending physician Physician/Medical use as the ed by the a detached for # みろれいして、 Division of Vital Records, P.O. signed by page 2 should be certific Physician: funeral director, Be P Aft r this Certification: Hospital or Attending within 24 hours after death, To the Funeral Director: A

**Funeral** 

Director

27 is marked other than "netural", or itams 23s or 28e-f show traumatic event, It a Modical Examiner must be notified at

the Maryland

72 hours after

12 should be filed within 74 h and Mental Hygiene. 7 la marked othar than "ne

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permit. Pages to Department of Findortant: If its eny injury or ot once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

Stred- Hageiston 19021740

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D28365

WH-5+1

State Registrar

Medical

31. Date filed (Month, Day, Year)

4 T Homicide

29a. Certifier

MAR 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -

SHAM.

32. Registrar's Signature

368

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

null

		For State Registrar  1. Decedent's Name (First, Middle, La	ist)	Cei	rtificate	of Death	2. Date of De	Rag. No.	Year	3. Time of Death			
Physicia /Medic Examin	al -	Elizabeth 4a. Facility Name (If not institution, giv			4b. City, To	own, or Location of Dea	March	11	2007 County of Death	1405			
Funeral			Sex 7. Age (In yrs	. last birthday)	If Under 1 Months	Hyattsvil Year ff Under 24 Hr Days Hours Min	S. 8. Date of Bir (Month, Da	iy, Year)	9. Birthp	George Solace (State or Fore			
Director		253-52-6003  Usual Residence of Decedent  10a. State 10b. County		73 Yrs.			Sep. 2	9, 19		eorgia  Od. Inside City Lim			
28a-f eho	rector	Maryland Prince			10f. Zip C		sville	10g. Citiz	en of Whal Cour	1 (X)Yes 2 □ h			
23a or	alDi	6305 Riggs R	oad , #114			20783			United	States			
be lied within / 2 nouts after death with the maryland tall Hygiene. Ad other than "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decede If Yes, specif	nt of Hispanic Origin? (y Cuban, Mexican, Pue Y No Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Americ Black, White, A.I.: Specify: Ame	ean fndian, elc. rican erican			
- 3	pieted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done during most of w	orking	16b. Kin	16b. Kind of Business/Industry				
should be filed withing Mental Hygiene. marked other than imatic event, its Mi			2		Culi	nary Chef	ame (First, Middle	Maiden		vate			
nould be to d Mental H narked ot natic ever	To Be	17. Father's Name (First, Middle, Las Adam G				TO, MOUTHOUS IN	Dora		*				
and Marian mari	F .	19a. Informant's Name/Relationship		19b. Mailin	ng Address (	Street and Number or I				Code)			
and the lith seminary the semin		Phimetto D. Lew 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. ☐Removal from State	Place of Dispo cemetery, cres	sition (Name matory or oth	er place)	Date	20c. Loc	32615 cation - City or To				
permit. Pages Depertment of h Important: If Its any injury or of		4 Donation 5 Other (Special Service Lice		01iv	2. Name and	Address of Parities	17/2007 Stewart F	unera					
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thet the death certificate it ed by the ettending physiological detection as the total for use as the total ed.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2	3d. Date of deliving Month	ery Day Year							
w requires thet the s been signed by th s should be deteche	d by Pt	Part II. Other significant conditions	contributing to death but not re	esulting in the u	inderlying cau	use given in Part I.				he cause of death bably 4 📆 Unkn			
elaw hesb je2st	complete		11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				24a. Was auto perf 1 Yes		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings avail ompletion of cause 2 \(\textit{ No}\)			
Physicien: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only						
Phys this al dii	<u>5</u>	1 ☐ Yes 2 📆 No  27. Manner of Death	1 ☐ fnpatient 2	1   Impatient 2   EH/Outpatient 3   DOA   4   Nursing Home 5   AH						Residence 6 Other (Specify)			
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To the Hoepital or Attentwithin 24 hours effect death To the Funeral Director: completely filled in by the	edicai Ceri	29a. Certifier 1⊠ Certifying F	building, etc. (Specially building) building, etc. (Specially building) building bui	nowledge, deat			ice, and due to the	cause(s)	and manner as s				
o the H	Medi	one) 29b. Signature and title of certifier	and manner stated.	./	1	License number	33, 33 21 1.10 1.1111		e signed (Month,				
F. W. T. 8	_	10		of le	1 1	00093	57		March 1				
71		30. Name and address of person who					attsvill		20781				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	larylan				ealth a		lental Hy	/gien Reg. N	$Z \cup U \cup I$	10	212
199			1. Decedent's Name (First, Middle, La	st)							2. Date of D Month		ay Ye <i>a</i> ı		e of Death
	Physici /Medio		Elias Asaur Har	ďv						March		14. 200		:59 A <sup>M</sup>	
	Examin		4a. Facility Name (If not institution, given		)		4b. City	, Town, or	Location	of Death		4	c. County of De	ath	
			Holy Cross Hosp	ital				Silve	r Spi	ring			Montgor	erv	
	Funeral		5. Social Security Number 6. 5	Sex 7. A	ge (In yrs.	last birthday)		er 1 Year	If Under Hours		8. Date of 8 (Month, D	irth ay, Year	9. B		ate or Foreign
	Director		NONE	<b>1</b> X M 2□F		Yrs.			3	35	3/14/		1	yland	
	pu 🛦		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Insid	de City Limits
	eho eho	5	Md. P.G.		100.0.	Fores		1							Yes 2 □ No
	10 N	Director	10e. Street and Number		<u> </u>	rores		p Code				10a C	itizen of What (	Country?	
	with	ᡖ	7701 Mane Lane				101. 2		747			109.0	U.S.A.	, out my .	
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Maryland 21215-0036	12 sh and ls r		19a. Informani's Name/Relationship Gerelle Q. Dodsor				-						or Town, State, Land 20'		
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وّ	in it		1 ☐ Burial 2 ② Cremation 3 [		9	lace of Dispo emetery, crer					3/20/0				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Depertment of Hygiene 21 is marked other than 1 naturel; or items 23e or 28e-1 ehow eny injury or other traumatic event, the Madical Examiner mant be notified at once.		4 ☐Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Cne	sapeak							Beltsvi		
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			23a, Part1. Enter the disease, or con	plications that cause	d the deat									Approx	imate
	Ohooisian		shock, or heart failure. List only Immediate Cause (Final											Onset	Between and Death
	Physician /Medical		disease or condition resulting in death)	w		ematur	ıty							3 <del>2</del>	Hrs
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o Ô	en er en er irial-ti		resulting in death) Last	Due to (or a	s a conseq	uence of):									
3760,	or Attending Physician: The law requires that the death certificate be executed that deeth.  Jirector; After this certificate has been signed by the attending physicien end birector; after this certificate has been signed by the attending physicien end in by the funeral director, page 2 should be detached for use as the burial-transit.	Icai	•	d											
<u> </u>	eath certifica attending pt for use as ti	Physician/Med	IF FEMALE:												
ဓ္ဓ	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 KFeta	Ideath 3		oregnancy					23d. Date of d Month	elivery Day	Year
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5	ding Physician: The lav h. Affer this certificete has funeral director, page 2	0	25. Was case referred to medical examiner?  1 ☐ Yes 2 📉 No	Hospital: 1 Inpat	iont 2	FR/Out-at-		26. Place of Death (							
ō	Phy rrthis aral d	: To	27. Manner of Death	28a. Date of In (Month, D		28b. Time of	Produpation: 3 DDA 4 Nursing Hor					Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
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Division of Vital Records,	or Attence fer deeth Director; I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of It	njury - At ho	ome, farm, str	eet, facto	ry, office			28f. Location City or To		and Number or I	Rural Route	Number,
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	To the Hospital or within 24 hours effe To the Funeral Dic completely filled in	edical (		nysician: To the bes											ise(s)
	the H iin 24 the F the F	ledi	one)	and manner s											
	To	×	29b. Signature and title of certifier	4				c. License		10			ate signed (Moi ch 14,2		ar)
(1	0		2 -el	M 3		in		D5:	22E	14		111			
M			30. Name and address of person who	•				_ (	Si lvo	r Sn	ring, 1	MG .	20910		
			Janez K. Hino 31. Date filed (Month, Day, Year)				en Ro	pad, '		_ <i>D</i> D.	- 1.19, 1	2010			
	Sta Registr		MAR 1 9 2007	diam JZ. ROUS	trar's Signa	all I									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 13, Day 2007 **Physician** Gladys M. Harris 5:30 p. **Medical** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick 414 N. Bentz Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

December 2, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 Tet 69 214-36-2310 1937 Maryland Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at Frederick Frederick Maryland Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 N. Bentz Street 21701 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Pivorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me than Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hospital 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eckenrode George Gurshon ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Betty Kaufman / daughter 12467 Woodsboro Pike/ Keymar, Maryland 21757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem.Garden 03/17/2007 Frederick, Marvland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Lig 1621 Opossumtown Pike/ Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. ATHEROSCIE MATERIAL VASUUM:

Due to (or as a consequence off): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Atteriding Physician: The law requires that the death certificate be executed Hypercho attending physician and for use as the burial-tran Due to (pr as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 1 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 2 5 Residence 6 Other (Specify) this 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes death. 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fter within 24 hours a To the Funeral Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description Description (some content of the cause)

Description Description (some cause)

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Description Description (some cause) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 040301 13 MAR 07 asuy 30. Name and addre s of person who a mpleted cause of death (Item 23a) (Type, Print) 1564 Opossumtown Pike/ Frederick, MD Casagrande Eugena 32. Registrar's Signature 31. Date filed (Mont Year) State 9 Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	,	Cei	rtificate of	Death	,	Reg. No.	Ji	10214	
~			Decedent's Name (First, Middle, Last)		**			2. Date of Dea	ath	Vans	3. Time of Death	
-	Physici /Medic		HOUSTON LEE HOLDEN 03/18/6						3/0 <b>7</b>	Year	5:32 Am	
	Examir		4a Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death						1 , 1 ,	4c. County of Death		
			PENINSULA REGIONAL	Medical Cen		0	bury		NECK			
	Funeral Director		223-24-7070	7. Age (In yrs. 183	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Day 0//02/	23°	9. Birthp	lace (State or Foreign htry)	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				1	0d. Inside City Limits	
	Maryl f sho ied a	Į.	VA Accomac	ek v	Vithams	5					1 Yes 2 No	
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Coun	ntry?	
	h with		6680 Neal Parker F	Rd.		2348	38		USA			
	deat sms (	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puer	pecity Yes or No-	- 14. Race	- Americ	an Indian,	
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 44-4		1 ☐ Yes 2 █ No			Specify.		Lack	
5-0	72 ho natur tical	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occup	pation during most of world)	rkina	16b. Kind of Bu	siness/Ind	dustry	
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121	filed within Hygiene. rther than '	ပိ	17. Father's Name (First, Middle, Last)		1016	- IIIGH	18 Mother's Nar	ne (First, Middle,			Academy	
anc	to pe	Be	Joe L. Holden						cher Holden umber, City or Town, State, Zip Code)			
Z	s 1 and 2 should be filed w f Health and Mental Hygie item 27 is marked other t other traumatic event, th	은	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	na Address (Street	·					
<b>≥</b>	and 2 sealth ar		Carolyn Holden, Wi			-	rker Rd.				,	
<u>6</u>	s 1 and 2 f Health item 27 i		20a. Method of Disposition	20b. P		sition (Name of matory or other pla		Date	20c. Location -		own, State	
E C	Page lent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State 1		Cemetery		24/07	Withams	s, VA	A	
Baltimore, Maryland	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Selvice Licens	ее	22	2. Name and Addre	ess of Facility				<del></del>	
<u> </u>	88 1 2 8		Jamud 11. D	Sele K.	(	Cooper &	Humbles	Funeral	Co., Acc	comac	e, VA	
			23 Part1. Enter the rise e, or composhock, or he rt in liure. List only	cations that caused the death ne cause on each line.	h. Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory ar	rrest,		Approximate Interval Between Onset and Death	
T	Physician		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	pour G	Rostrontes	atinal 6	Luding			2 days	
7	/Medical Examiner		resulting in death)	Due to (or as a consequence). Mutaetatie	uence of):	120 of 4	Palazies	<i>;</i>			2 8 4 4 4 11	
		10	Sequentially list conditions,	Due to (or as a consequence)	uence of):	May 10	re o ne				gier,	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Preudomo		ERSA					14 days	
Ć,	execu n and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						14 days	
68760,	icate be executed physician and s the burial-transit			Cacetà re	not f.	oi lure	<b>,</b>			/	14 doys	
	rtificat ng ph	Medical	IF FEMALE:									
Box	eath ce attendir for use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	y			e of delive		
	at the dea by the at stached fo	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5	Other (specify) _	·		Mor	itri	Day Year	
P.0	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Ph	Part II. Other significant conditions col	ntributing to death but not resi	ulting in the u	nderlying cause giv	ven in Part I	23e. Did to	obacco use contr	ibute to th	ne cause of death?	
ds,	signed be det	d b		_	_			1 🗆 1		3 ☐ Prob		
Ö	w requir been si should I	Completed by	non insulin der	WALTENT ALIC	butes			24a. Was	24h N	Vere guto	psy findings available	
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<u>e</u>			Abdominal L 25. Was case referred to medical	X DIFIC XXVIII	ige IV	<b>,</b>	26 Place of Do	1∐ Yes ath (Check only o		□Yes	2 No	
>	Physician: r this certificaral director, I	To Be	examiner?	Hospital: 1 ★Inpatient 2 □	ER/Outpatier	nt 3 DOA Oth	nor'	Home 5 ☐ Resid		er (Specifi	iv)	
ō	ding Phys h. After this ( funeral dir		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				now injury occurr		*/	
<u>i</u>	Attending r death. ector: After by the fune	atio	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No									
Division or Vital Records,	after der Directo	27. Manner of Death 1 Manual 5 Pending investigation 2 Accident 3 Suicide 4 Homicide  288. Date of injury - At home, farm, street, factory, office 286. Injury at Work? 1 Yes 2 No  286. Describe how injury of Injury at Work? 1 Yes 2 No  286. Describe how injury of Injury at Work? 1 Yes 2 No  286. Describe how injury of Injury at Work? 1 Yes 2 No  287. Street and No City or Town, State)								Number or Rural Route Number,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifler (Check only one)	sícian: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as s	tated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	V Pus n	19	29c. Licens	se number 14 <b>8</b> 14		29d. Date signed			
e	A 1+1		30. Name and address of person who con PANPIT P. KLUG	ompleted cause of death (Item 145 E Cour	1 23a) (Type,	Print) wt, So	lisbury	, mo.	21801	,		

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 9 2007

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day WILLIAM HOOPER ROBERT March 16, 0014 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death REGIONAL PENINSULA LENTER HLISBURY 11 COMICO MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-27-1936 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months **™** M 2□ F Davs Hours 70 Massachusetts 028-26-8442 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Blades Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 E. 4th St 19973 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🎗 ☐ No Specify Specify: white 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leslie J. Hooper Edith C. Stockwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hooper - son 141 Glenwood Rd, Rutland, MA. 01543 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Capitol Crematory 3/18/2007 Dover, DE 4 □ Defialtion 5 □ Other (Specify) 21. Signalur Fune Service ticense John A. Cranston 22. Name and Address of Facility Cranston Funeral Home P O Box 967, Seaford, DE 19973 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Upper Estrointestinal Dutt (or as a consequence of): bleeding Sequentially list conditions, if any, loading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Congestive 1∏ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner** Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or ite

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra

Maryland 21215-0036

3altimore,

with the Maryland

death

burial-tran signed by

The law requires that the death certificate be executed

or Vital Records, P.O. Box 68760,

Division

attending physician for use as the buria ed by the a

Physician/Medical ğ Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 2 Certification:

To the Hospital or Attending Physician:

State Registrar

Medical

5 Pending investigation

27. Manner of Death

2 Accident

4 ☐ Homicide

29b. Signature and title of certified

3 ☐ Suicide

29a. Certifier

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

0053394

29c. License number

29d. Date signed (Month, Day, Year)

MARCH 16, 2007

and address of person who completed cause of death (Item 23a) (Type, Print) FREY MD SALISBURY Md 21801 ANTHONY 1008. CARRULL ST.

31. Date filed (Nonth, Day, Year) 32. Registrar's Signature

MAR 1 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per Mis C866,04/12/07dhb Reg. No. 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** 0525M 2007 Holland /Medical lahn 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not ipstitution, give street and number) Examiner PENINSULA KEGIONAL MEDICAL WICOMICS LENTER DALISBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours Months Min 1 ☑ M 2 ☐ F 578-09-5713 Usual Residence of Decedent 90 8-28-1911 Director 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 XYes 2 No New Church VA Director Hccomac K the ! 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 o e 23415 "natural", or items 23a o Creck Completed by Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry alth and Mental Hygiene.
27 is marked other than "
r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Stationary International Union Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lempleton Holland ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 stands of the permit of Health at Important; If item 27 is any injury or other trauonce. Stoney New Church, VA 3043 Holland reck heo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State Exmore, VA Chincoteaque, VA Occohonock Cremator 4 ☐ Donation 5 ☐ Other (Specify) 20/2007 21. Signature of Funeral Service Licensee 22 Name and Address of Facility amanda e-Betts Salver Funeral Home, Inc. Church St. 6337 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): SOPO Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit rostat CERTIFICATION Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ Month Day 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes <del>2</del> No 2 ER/Outpatient 3 DOA 1 Inpatient ၉ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury 1 Natural 5 ☐ Pending Unknown M 1 ☐ Yes 2 ★No Subject fell 03/16/2007 investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) New Church VA 33043 Stoney Creek Rd, Home 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO041211 un. an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

FERNANDO

31. Date filed (Month, Day, Year)

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1 9 2007

CANHOLL

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Registrar's Signature

St. SALISBURY Mol

			1- State of Maryland	Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 17   02   8
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medio		Elizabeth B. Jacobs	March 24, 2007 0425AM
	Examir		4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location ol Death 4c. County of Death
			Citizen's Nursing Home	Havre de Grace Harford
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 1 ☐ M 2 2 2 F 88	Ast birthday) Il Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year) North Office (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location 10d. Inside City Limits
	Maryl -f eho	ğ		1 M Vas 2 TNo
	r 28a	irec	10e. Street and Number	vre de Grace  101. Zip Code 10g. Citizen ol What Country?
	th wit	a D	300 Commerce Street	21078 U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show sayl fujury or other treumatic evant, I're Maylical Examiner must be muilled at anone.	by Funeral Director	3 Ma Widowed 4 Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:  14. Race - American Indian, Black, White, etc.  Specify:  White
Õ 2	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working)  16b. Kind of Business/Industry
21215-0036	han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)
2	Hygier Hygier Ther ti		12 2 17. Father's Name (First, Middle, Last)	Secretary Civil Service  18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	Mental I	To Be		Sadie Hughes
Mar	nd 2 shoulth and 27 le mar		19a. Informant's Name/Relationship (Type, Print)  Joan Hines (daughter)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Worthington Ct., Aberdeen, MD 21001
ore,	of Heg			ace of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other place)
<u>E</u>	Page ment cant		Lagounal 2   Cremation 3   Removaliform State	ngel Hill Cemetery 03/27/07 Havre de Grace, MD
Baltimore,	permit. Departitimport. eny Inj.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart lailure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
)	Physician	ŕ	Immediate Cause (Final disease or condition	MA AUN EN
	/Medical Examiner		resulting in death)  Due to (or as a conseque	
	Zamino	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence)	U Mi or
B	ited nsit	nine	Cause (Disease or injury	NA 9
, ,	execu n and ial-tra	Examiner	that initiated events c. Due to (or as a conseque	ance of):
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	rtifica ng ph	Medi	IF FEMALE:	
ă	ath ce ttendii or use	an/	23b. Was decedent pregnant in the past 12 months? 23c. Il yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of	death 3 Ectopic pregnancy
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۳.	that hed by deta	y Ph	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Division of Vital Records,	w requires been sign should be	ed b		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
000	e law re has bee je 2 sho	Completed		24a. Was an 24b. Were autopsy findings available
ř	ysicien: The lis certificete he director, page	E O		autopsy prior to completion of cause of performed? death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
ita /	icien: Th certificete ector, pag	Be (	25. Was case relerred to medical examiner?	26. Plage of Death (Check only one)
5	Physi this c al dire	2		R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
<u>ــــــــــــــــــــــــــــــــــــ</u>	ding Ph h. After th funeral	tion	1 Natural 5 Pending (Month, Day Year)	28b. Time of Sec. Injury at Work? 28d. Describe how injury occurred Work? 1 □ Yes 2 □ No
<u>ISI</u>	Atten deat octor; y the	fica	3 Suicide 6 Could not be 28e Place of Injury - At hom	ne, larm, street, factory, office  28f. Location (Street and Number or Rural Route Number,
ă	el or s after	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, f.	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowl one)  1 Medical Examiner: On the basis of examination and manner stated.	ledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	withir Comp	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			► Hi sup sim MD	7464 2 3/26/07
	10	Ì	30, Name and address of person who completed cause of death (Item 2)	23a) (Type, Print) AND HIS MID 21078
n , d	Sta	te	31. Date filed (Month, Day, Year) Registrar's Signatu	re de la companya de la companya de la companya de la companya de la companya de la companya de la companya de
	Registr		MAR 3 0 2007 Seem &	Apole

Elizabeth

			For 1_ State	State of Marylar		artment of Healt rtificate of Dea				
			Registrar  1. Decedent's Name (First, Middle, Last)		- Cei	illicate of Dea		. Date of Dea	eg. No. 2	3. Time of Death
	Physici		Lois B. Kraft					Month March 13	Day Yea	
	/Medic Examin	_	4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or Local	tion of Death		4c. County of De	ath
-			Montgomery General Ho			01ney	0411		Montgome	
	Funeral Director		579-52-3182	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year If Un Months Days Hor	urs Min.	Date of Birth (Month, Day April 8,	, Year)	Birthplace (State or Foreign Country) Virginia
	land		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Mary fed a	ţ	Maryland Montgomery	,		Silver Spring	g			1 ☐ Yes 21 No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	th with		14510 Homecrest	Road, #2025		20906			U.S	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 △ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2 ☑ No Spe	ic Origin? (Speci exican, Puerto Ri ecify:	fy Yes or No- can, etc.)	14. Hace - Ar Black, Wi Specify:	nerican Indian, hite, etc. White
21215-0036	72 hou natura ical E	Completed by	15. Decedent's Educa (Specify only highest grade of	ttion	16a. Dece	dent's Usual Occupation	most of working		16b. Kind of Busines	ss/Industry
218	ithin 7 ne. nan "r Med	lg l	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	_		Donantm	ont Store
	should be filed within and Mental Hygiene. s marked other than "umatic event, the Me	ខ	12 Tether's Name (First Middle Leat)			Sales Consulta		First Middle	Maiden Surname)	ent Store
Maryland	l be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)  Eppa H. Brown			10.1	Mae F. Bo		maidon damamo,	
Ž	should ind Men marke umatic	٩	19a, Informant's Name/Relationship (Type	e. Print)	19b. Maili	ng Address (Street and N			r, City or Town, State	ə, Zip Code)
Σ	nd 2 salth ar 27 is r trau		John Kraft - Son	,	66 S	usan Drive, Nev	w City, Ne	w York	10956	
re,	s 1 an of Hea Item othe	100	20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place)	Da	te	20c. Location - City	or Town, State
E O	Pages nent of I ant: If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movai irom State		n Crematory	3/21/20	007	Brentwood,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	Senton	H	2. Name and Address of F ines=Rinaldi Fu 1800 New Hampsh	uneral Hor		er Spring. M	
			23a. Part1. Enter the disease, or complice shock or heart failure. List only one	ations that caused the dea						Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Lunc Due to (or as a cons	quence of):	S				Onset and Death  2y-curs
F		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or Irijury that initiated events c.	Due to (or as a conse	equence of):					
68760,	icate be executed physician and s the burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					
687		edical	u.		-					
.O. Box	at the death certifi by the attending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome pf preg 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
Δ.	that the		Part II. Other significant conditions cont	ributing to death but not re	esulting in the	underlying cause given in	Part I.	23e. Did to	bacco use contribute	e to the cause of death?
rds	quires n sign ald be	d by	Hypertensic	)n				101	res 2 No 3 □	Probably 4 Donknown
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was autop perfo 1  Yes		
Vital		Be C	25. Was case referred to medical examiner?				Place of Death	Check onl o	ne	
or V	ilis dir	10	1 ☐ Yes 2 ☑ No		☐ ER/Outpatie				dence 6 Other (S	pecify)
o u	ing Affe		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injury at Work?  M 1 ☐ Yes	İ	3d. Describe h	now injury occurred	
Division	r Attenter death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, s			Bf. Location (S City or Tox		r Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C		ician: To the best of my k er: On the basis of exami and manner stated.						
	To th Within To th compl	Me	29b. Signature per little of certifier	)		29c. License nur	mber		29d. Date signed (M	onth, Day, Year)
			CKS (M)	PAYS	SICIA	N 63	168		3/13/	07
	>			mpleted cause of death (It					,	
			Shyam Park	hìc MD 32 egistrar's Sig		ledical Center	Drive, Ro	ckville,	Maryland 20	1850
	St Regist	ate rar	31. Date filed (Month, Day, Year)	7 Segistrar's Sig	K A	meter				

DHMH 17 Rev 1/2001

			Pleas	e Type or Prin				-	_	
			for State Registrar Amend	#5 Per FH G		epartment of F			eg. No:	10000
			Registrar     Decedent's Name (First, Middle,			GOTTIMOGRO OF		2. Date of Deat	th CUUI	3. Time of Death
	Physicia							Month 3/25	Day Year / 2007	5:10 A <sup>M</sup>
	/Medic		William Morr  4a. Facility Name (If not institution,			4b. City. Town, o	r Location of Death	3/23/	4c. County of Deat	
	Examin	er	North Hamton			Frede			Freder	
	Funeral				e (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		401 430-30-3007	1 <b>∏</b> M 2□F	78	Yrs. Months Days	Hours Min.	(Month, Day, 6 / 3 0 /		uintry) ` K Y
۰	4	Ì	Usual Residence of Decedent					0/00/		
	how at		10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits
	e Ma a-f s tified	cţ	MD Freder	rick	Fred	erick				1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath w 23a ust b		5655 Sandy Co			2170			USA	
	r des tems er m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of H If Yes, specity Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	s afte ; or it amin	by Fi	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Van Civa	No 	1 ☐ Yes 21 No	Specify:		Specify: W	hite
215-0036	y within 72 hours after death with the Marylan glene. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	D D	15. Decedent's	Year or Dates:		Decedent's Usual Occup	nation		16b. Kind of Business/	
2	n 72 "nat edic	Completed	(Specify only highest	grade completed)		(Give kind of work done life. DO NOT use retire	during most of worked)	king	Tob. Talla of Edolffess	madeny
72	withi ene. than he M	E	Elementary/Secondary (0-12)	College (1-4or 5		Electrici			Phillip N	Morris Co.
LZ 0	flied within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ther the Medical Examiner must be notified at		17. Father's Name (First, Middle, L	ast)					Maiden Surname)	
a	ould be Mental arked o	To Be	Elbert Floyd	Leger			Estella	a Britt	ain	
Maryland	s 1 and 2 should be filed of Health and Mental Hyg item 27 Is marked other other traumatic event, to	_	19a. Informant's Name/Relationsh	ip (Type. Print)	19b	. Mailing Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, State, 2	Zip Code)
	and 2 salth a n 27 is er trai		Jacqueline S.	Leger W	ife 56	555 Sandy	Court F	rederio	ck, MD 21	701
ē,	es 1 a of Hez fitem		20a. Method of Disposition		cemeter	Disposition (Name of ry, crematory or other pla		Date	20c. Location - City or	Town, State
Ê			1 XBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp			Hill Cem.	1	1/2007	Louisvil	e KY
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service L	igensee	Juave	22. Name and Addre	ess of Facility K.e.	enev &	Basford	P.A. F.H.
ñ	an)		- bluf X	lear M	101176	106 East	Church	St. Fr	ederick,	MD 21701
r	2)		23a. Part1 Enter the disease, or shock or heart failure. List of	complications that caused	d the death. Do r	not enter the mode of dyi	ing, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
<u>.</u>	Physician		Immediate Cause (Final disease or condition	67.71	osclero	tie Carl	ovascul	o- Di	SPACE	Onset and Death
	/Medical		resulting in death)		a consequence					/
	Examiner		Sequentially list conditions	b						
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):				
3	ecute and -trans	cam	that initiated events resulting in death) Last	C	a consequence	ot).				
9	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	=	,	Due to (or as	a consequence	01).				
687	cate b	Physician/Medica		d						
9 ×	ding page as	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy				23d. Date of de	livon
Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	СУ		Month	Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	a timo or dodar	0 <u> </u>				
<b>J</b> .	ires that the de signed by the a I be detached i		Part II. Other significant conditio	ns contributing to death b	out not resulting in	the underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute t	the cause of death?
Records,	uires 1 sigr 1d be	d by	Diabetes 1	Mellito	5 Zs	ipe IL		11	′es 2□No 3□P	robably 4 Unknown
Ö	w require been sign should b	ete	Concertion	- Hear	+ 4	21/12/10		24a. Was a	an 24b. Were a	utopsy findings available
Re	he la e has age 2	Completed	01 01	1 1'	DI	CATTO . C	7	autop	med? death?	completion of cause of 2  □ No
Vital			25. Was case referred to medical	pruchive	1010	nouary.	26. Place of Dea	th (Check only or	~	5 2 NO
	ysicia s cer direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/Ou	tpatient 3 DOA Ot	hor:		lence 6 Other (Spe	ecify)
0	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Inju		Time of 28c. Injury Wo			ow injury occurred	
Division or	ath. r: Aff	atio	1 Natural 5 Pending 2 Accident investig	ation			Yes 2□No			
<u>S</u>	r Atte	ertification:	3 Suicide 6 Could n 4 Homicide determi	ned   286. Place of III	jury - At home, fa	rm, street, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
Õ	tal or rs after al Di	Cer						<u> </u>	· 	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director,	cal	(Check only 2 ☐ Medical I	g Physician: To the best Examiner: On the basis of	of examination ar					
	the hin 2 the mple	Medical	one) 29b. Signature and title of certifier	and manner s	tated.	29c, Licen	se number		29d. Date signed (Mon	th. Dav. Year)
	5 ± ≥ 5		7/1	Hal.	11/1 0	7 -	77:0-	,	3-71	-7003
	1.1		30. Name and address of person	who completed course of	death (Itom 22c)	(Type Print)	0//7/		060	LUG
	104,		Alau Pola			-11.2	7th 5+	ret	Frederic	4 MM Z1701
	Sta	ite	31. Date filed (Month, Day, Year)	Regist	trar's Signature	1 10	- 21	····	white the	7.10
	Regist	rar	MAR 3 0 2	007 Bleen	, J. A.	WARE .				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2007 March 8, Toy Soon Lee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 12308 Overpond Way Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🖾 F 578-58-3858 88 March 16, 1918 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If them 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 12308 Overpond Way 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown Wong 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Lee - Son 12308 Overpond Way, Potomac, Maryland 20854 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Dong for 5 □ Other (Specific) 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot Washington National 3/19/2007 Suitland, Maryland Cemetery 22. Name and Address of Facility 21. Signat re of uneral source Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part L Enter the disease, o shock, or heart failurd. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Acute Stroke disease or condition resulting in death)

**Physician** /Medical Examiner

burial-trai

attending physician for use as the buria

signed by the a

page 2

director,

After this funeral

within 24 hours after death

To the Funeral Director:
completely filled in by the f

(0)

State

To the Hospital

þ

Completed

Be

Certification: To

Medical

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine that initiated events resulting in death) Last

Due to (or as a consequence of): Hypertension Due to (or as a consequence of):

Atrial Fibrillation Due to (or as a consequence of):

Physician/Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 Unknown

23c. If ves. outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 5 Other (specify) 9□Unknown

3 ☐ Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

China

U.S.A.

Restaurant

14. Race - American Indian

Asian

Black, White, etc.

Ρ.

3:33

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐Yes 2 No

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2x No 3 Probably 4 Unknown 24a. Was an

autopsy performed? 2K No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 □ Nursing Home 5 ⊠ Residence 6 □Other (Specify) Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

my

29c. License number

Bethesda, Md.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # Ave Wisconsin

Hospital:

31. Date filed (Month

gistrar's Signature

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>007</u> Physician Month Shirley LEVY March 13, 8:21 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospice Silver Spring 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 □ F Director 150-09-4740 Illinois 91 1916 Jan. 23, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director Maryland Montgomery Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20910 1220 Blair Mill Road #1200 United States 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene.

Ant: If ifean 27 is marked other than "natural", or items 23, and: If item 27 is marked other than "natural", or items 13, any or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐ No Specify white þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 GSA/FEMA Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hyman Levy Clara Hoffman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Levy Ritchey, Niece 1928 Brevard Road, Hendersonville, NC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of Important: If its
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) King David Memorial Garden 03/16/07 Falls Church, VA 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Livensee Carroll St. NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-Hodgkins Lymphoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autonsy performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) Hospice 27. Manner of Death Certification: 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Attending 1X Natural 5 Pending investigation after death. 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within 29b. Signature and File of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) MAR 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

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				<b>ype or Print in E</b> State of Marylan				-	•	
			1 - For State Registrar		-	rtificate of		, ,	. No. 2 () () 7	10223
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Florence	Zelo	ris	Loga	n	2. Date of Death Month 03	Day Year 19 2007	3. Time of Death 0620
)	Examir	ner	4a. Facility Name (If not institution, give st MEMORIAL HOSPITAL	reet and number)			or Location of Death		4c. County of Death	1
	Funeral	7	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	CUMBE If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	ALLEGANY 9. Birth	place (State or Foreign intry)
	Director		419-40-6639 □ 1□ Usual Residence of Decedent	м 2 <b>Д</b> F 72	Yrs.	Months Days	Hours Min.	06/02/19	934 Alab	ama
e Marylan	a-f show tified at	ctor	10a. State   10b. County   MD   Allegany		y, Town or Lo	Cumber	land			10d. Inside City Limits 1 X Yes 2 No
h with th	23a or 28 st be no	al Director	10e. Street and Number 8 Fort Hill A	Avenue		10f. Zip Code 2 1	502	10g	. Citizen of What Cou USA	intry?
<b>U.So</b> urs after deal	al", or items ? Examiner mu	by Funeral	11. Marital Status 1.  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
7.0-C17	e. an "natur Medical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	oation during most of worki d)	ing 16	b. Kind of Business/I	
ed wit	ygiene ner the		12		F	Homemaker			Home	
yrar id ould be fii	Mental H larked oth latic even	To Be	17. Father's Name (First, Middle, Last) Dink	Bowman	Hose		Lealer	(First, Middle, Ma		White
Mar od 2 sh	Ith and 27 is m traum		19a. Informant's Name/Relationship (Type L. Roxanne Harris		1		and Number or Rura Avenue, C		ity or Town, State, Zi	
s 1 ar	other		20a. Method of Disposition	20b. P		sition (Name of matory or other place			c. Location - City or T	
permit. Page	Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur of Fulleral Service Licensee	Eve	rgreen	Mem. Par 2. Name and Addre	k Cem. 03	ams Famil	y Funeral	Indiana Home, F.H. 21502
		Г	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the death						Approximate Interval Between
/I	ysician Medical aminer		Immediate Cause (Final disease or condition resulting in death)		ARTERY Jence of):	DISEASE	3			Onset and Death
ate be executed	attending physician and for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequ						
The law requires that the death certificate be executed	by the attending pached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	z. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy	,		23d. Date of deliv	ery Day Year
equires that	been signed by the s should be detached	þ	Part II. Other significant conditions control RENAL FAILURE	ibuting to death but not resu	Ilting in the ur	nderlying cause give	en in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to t	J
The law r	ite has	Completed	DIABETES MELLITU	S				24a. Was an autopsy performed 1∐ Yes 2	prior to co	opsy findings available impletion of cause of
siclar	certif	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1 ☐ Inpatient 2 🔏		Othe	26. Place of Death			
g Phy	ter this neral d	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	COLDON	4 LI Nursing Hon	ne 5 Residence 8d. Describe how i	e 6 Other (Special of the first	(y)
tendin	tor: Af the fur	catio	1 Natural 5  Pending 2  Accident investigation 3  Sulcide 6  Could not be		Injury	M 1 🗆	Yes 2 □ No			
Ital or At	ral Direct Iled in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	)		1	City or Town, S	,	
the Hosp	within 24 hours after deam.  To the Funeral Director: After this certifice completely filled in by the funeral director, t	Medical	one) Medical Examine	ian: To the best of my known: On the basis of examinat and manner stated.	vledge, death ion and/or inv	estigation, in my o	pinion, death occurre	ed at the time, date	and place, and due t	o the cause(s)
To	2	2	29b. Signature and title of certifier			29c. License	32PU		Date signed (Month, arch 9, 2	
	nds		30. Name and address of berson who com Sunil K. Gup				Cumberla		21502	
*	Sta Registra		31. Date filed (Month, Day, Year)  MAR 0 9 200	32. Registrar's Signat	ure	Carles				
			(HIPALL V C		1	J				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician HENRY UPSHER LANGFORD III MARCH 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death 4b. City. Town, or Location of Death CHARLES COUNTY NURSING & REHABILITATION CENTER LA PLATA **CHARLES** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**□**M 2□F Days Min. Hours FERUARY 25, 1925 MARYLAND 219-14-3133 Director 82 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location il Hygiene. other than "natural", or Iteme 23a or 28a-f show vent, tra Mudical Examinar must be notified at 10d. Inside City Limits 1 TYes 2 □ No Director MARYLAND CHARLES BRYANS ROAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2590 MARSHALL HALL ROAD 20616 UNITED STATES within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

14 Yes 2 No 1943-11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify: ģ Specify: BLACK 3 Widowed 4 Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 YEAR (1-4or 5+) MAIL CLERK FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 end 2 should b f Health and Ments item 27 le marked HENRY UPSHER LANGFORD, JR. ZOLA WILLIAMS LANGFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELVIRA C. LANGFORD / WIFE 2590 MARSHALL HALL ROAD, BRYANS ROAD, MARYLAND 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Peges nent of hand: If ite 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CHURCH CEMETERY MARCH 21,2007 POMONKEY, MARYLAND 21. Sandure of Funeral Fervices icensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C, THURNIUN JOHNSON MOO583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) Cancer MA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, loading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit ettending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Dementia PRMENSION Completed 2 No 1 Tyes 3 Probably 4 Unknown this certificete has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 12No Hospitel or Attending Physician: : After this certifical funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number

DOO 61614 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R. Sindhwarl March 19th, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. SINDHWAN 1 11350 PEMBROOKE SQUARE, WALDORF , MARYLAND 31. Date filed (Month Nar Year) 9 32. Registrar's Signature State 2007 Registrar

DHMH 17 Rev 1/2001

	_	1 - For State Registrar	State of M		ertificate of		d Mental Hygi	ene 0 0	7 10225
Physi	rian	Decedent's Name (First, Middle, Las					Date of Death     Month		3. Time of Death
/Med			LAND				March	24, 200	
Exam	iner	4a. Facility Name (If not institution, give 723 LaVale Terra			4b. City, Town, or		eath	4c. County of	
Funera		5. Social Security Number 6. Se		e (In yrs. last birthday	LaVale	If Under 24 F		ALLe	egany Birthplace (State or Foreign Country)
Directo			□M 2∏F	88 Yrs.	Months Days	Hours M	fin. (Month, Day, Sept. 22		Ohio
2		Usual Residence of Decedent		140.00			- SOPE LI	7.10.10	
anyla	2	MD Allega		10c. City, Town or I	ocation.				10d. Inside City Limits
ith the Marylar or 28e-f ehow	ecto	MD Allega	пу	LaVale	10f. Zip Code		10	g. Citizen of Wha	1 Tyes 2 No
with	Funeral Director	723 LaVale Terra	CO		2150	2	10		
Jeath	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of H	ispanic Origin?	(Specify Yes or No-	U.S.A. 14. Race -	American Indian,
ore, Maryland 21215-0036  s. 1 and 2 should be filled within 72 hours effer death with the Maryland of Health and Merital Hygiene.  Item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumatic event, the Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	uerto Rican, etc.)	Specify:	White, etc. White
5-0	ted	15. Decedent's Edi (Specify only highest grad		16a. Dec	edent's Usual Occup	ation	working 1	6b. Kind of Busin	ess/industry
12 in in in in in in in in in in in in in	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	e kind of work done o DO NOT use retired	daning most or (	working		
d 21 Hygier other th	Co		2	Н	omemaker			Home	
Maryland nd 2 should be file lith and Mental Hy 27 le marked oth	Be	17. Father's Name (First, Middle, Last) Arthur William A	nanet Kon	<del>-</del>			Name (First, Middle, M		
arylan should be and Mental marked o	၉	19a. Informant's Name/Relationship (T		100000000000000000000000000000000000000	ling Address (Street		Elizabeth		
and 2 sauth and 2 sauth and 27 le		Kurt D. Moreland					e, Xenia,	- Making	5
re, M s 1 and 2 t Health Item 27 other tr		20a. Method of Disposition	<u> </u>	20b. Place of Disc				OH 4538 ROc. Location - Cit	
Pages nent of H int: If Ite		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify			st Meml. P		/28/2007	Cumber	cland, MD
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other		21. Signature of Funeral Service Licens	000		22. Name and Addres Hafer F	ss of Facility	Service, F	P. A.	
		23a. Part . Enter the disease, or comp slock, or heart failure. List only of	lications that cause	d the death. Do not en	T3UZ Na	CIONAL ig, such as card	Highway, I	.aVale, 1 st.	Approximate
Physiciar		Immediate Cause (Final							Interval Between Onset and Death
/Medica		disease or condition resulting in death)	<u> </u>	a consequence of):	TEMMT P	MILURO	4-		Two Yekns
Examine				ATED CA	ROIOMYON	PATHY			Two Yems
	Jer	Sequentially list conditions, if any, leading to immediate		a consequence of):	V -13. 13.11[ 01				
8760, % rate be executed hysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
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I Records, P.O. Box 68760, " The law requires that the death certificate be executed are has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	•	d						
Box 6 sath certific attending p for use as	/Med	IF FEMALE:	23c. If yes, outcome	of programmy					
Box 68  Beath certificate at the search of t	ian	in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date o Month	f delivery Day Year
P.O. I	nysic	1 ☐ Yes 2 DSNo 9 ☐ Unknown	9□ Unknown	. time or again					
IS, P	by Pr	Part It. Other significant conditions co	ntnbuting to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribu	ite to the cause of death?
Cords  * require.  been sign should be							1 Tes	s 2 No 3[	Probably 4 Unknown
S bee	Completed						24a. Was an		re autopsy findings available
Re( The law te has	E						<ul><li>autopsy perform</li><li>1 ☐ Yes 2</li></ul>	ed? dea	r to completion of cause of th? Yes 2 No
f Vital Roysicien: The I	BeC	25. Was case referred to medical				26. Place of E	Death (Check only one	1-	100 242,10
Of V Physic this ce at direc	To	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1 🗌 Inpatie	ent 2 ER/Outpatie	ent 3 DOA Oth	er: 4 ☐ Nursing	g Home 5 Resider	nce 6 Other	(Specify)
Vision of Vital Attending Physicien: r death. ector: After this certifice by the funeral director, to		27. Manner of Death 1 25 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury		y at k?	28d. Describe how		
SIO tendi leath. tor: A	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
in Diffe	Certification:	4 Homicide determined	28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office		281. Location (Streetly or Town,	eet and Number ( State)	or Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exem	rsicien: To the best iner: On the basis o and manner st	f examination and/or i	th occurred at the tin nvestigation, in my o	ne, date and pla pinion, death o	ace, and due to the car ccurred at the time, da	use(s) and manne te and place, and	er as stated. I due to the cause(s)
To the within To the Comp.	W	29b. Signature and title of certifier	e u	2	29c. Licenso	e number	sky (and) 1	d. Date signed (A	Month, Day, Year)
17		30. Name and address of person who c	ompleted cause of c	death (Item 23a) (Type	Print)				
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature			/		
DHMH 17 Rev 1	*	MAK 9 N ZUI	Julius	1 St M					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🧻 1 - State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 23, MOFFETT 2007 8:50 P LAWRENCE March EARL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Laurelwood Center Elkton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 11/22/1936 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Yrs 215-34-1990 70 Director Maryland Usual Residence of Decedent 10a. State t 0b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, I's Medical Examinar must be notified at 1 Yes 2 No Director Forest Hill MD. Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21050 2359 Putnam Road United States permit. Pages 1 and 2 should be tiled within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a applicity or other traumatic event, The Medical Examples reserved. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Drafting Koppers Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moffett John Minnie Cullum 2 Earl Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Moffett/Wife Forest Hill, Md. 21050 2359 Putnam Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Mem Gardens 3/28/2007 Bel Air, Maryland Bel 21. Signature of Euneral Service Lidentee 22. Name and Address of Facility Jarrettsville, Maryland Melster Kurtz & Son Funeral Home, P.A. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) mousta **Physician** HANE /Medical Due to (or as a consequence of) Examiner 37 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, ettending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 312 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home ဥ 1 🗌 Yes 20 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Naturat 5 Pending Intury 1 TYes within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 3 Suicide 6 Could not be Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) 26 MAROT on who completed cause of death (Item 23a) (Type, Print) 30. Name and address NEWLASTE DE 19720 CHRCHMAUS 31. Date filed (Month, Day, Year) 32. segistrar's Signature State MAR 3 0 2007 Registrar

			For State Registrar  1. Decedent's Name (First, Middle, Last	State of Mar	yland / Dep	delible Ink. Engartment of Health rtificate of Deal	n and Mental	Hygier	ne 2007	10227
	hysici /Medio	cal	Leticia	Montalv	0		Mon Mar	ch 1	4,2007	3. Time of Death 11:00pM
E	Examin	er	4a. Facility Name (If not institution, give 800 Jubal Way	street and number)		4b. City, Town, or Location Frederick			Freder	
	ineral rector		5. Social Security Number 6. Se 578-21-5362 10 Usual Residence of Decedent		(In yrs. last birthday) 7 Yrs.	If Under 1 Year If Und Months Days Hour	ter 24 Hrs. 8. Date s Min. (Mon Jul	of Birth th, Day, Yea Y 13	ar) Co	thplace (State or Foreign buntry) Mexico
e Maryland	ia-f ehow	ctor	10a. State 10b. County MD Frederi		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 📉 No
th with th	23a or 28 lat be no	Funeral Director	10e. Street and Number 800 Jubal Way			10f. Zip Code 21701		10g. (	Citizen of What Co	ountry?
. I Z I 3-UU30 within 72 hours after death with the Maryland ane.	r than "natural", or itams 23a or 28a-f ehow the Medical Examinar r tast be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic of Yes, specify Cuban, Mexical 12 Yes 2 No Special	Origin? (Specify Yes can, Puerto Rican, et ify: Mexicar		14. Race - Ame Black, Whit Specify:	
ithin 72 ho	Medical	Completed	15. Decedent's Edu (Specify only highest grad.	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired)	ost of working		Kind of Business	
be filed tal Hygi	od othe	Be	12 17. Father's Name (First, Middle, Last) unobtainable		Ca		ther's Name (First, M	liddle, Maide		Company
e, Maryla 1 and 2 should t Health and Men	~ =	٦ م	19a. Informant's Name/Relationship (Ty Ricardo Montal		19b. Mailir nd 800	ng Address (Street and Num Jubal Way	nber or Rural Route I	Vumber, City	or Town, State, I	
Pages 1 a	= 0		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, cren Chesape	natory or other place)	Date 3/15/200		Location - City or	
permit. Depart	Important: If eny injury or once.		21. Signal of Fineral Service Vicens	4	9	HTLTPAdD: RT 241 Columb	ia Blvd.	Silve	SERVI	CE,P.A. ng,Md2091
	dical		23a. Part1. Enterthe disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.  Lung Ca  Due to (or as a c	ncer	er the mode ol dying, such	as cardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death 8 months
lificate be executed	a price	dicai Examiner	Sequentially list conditions, and leaving to in Tracilate cause. Enter Underfuge Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c						
hat the death certifical	d be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
The law requires that the	should be deta		Part II. Dther significant conditions con	tributing to death but n	ot resulting in the ur	idertying cause given in Par	t I. 23e.	Did tobacco		the cause of death?
for Attending Physicien: The law requires the electron death of the law requires to be electron. After this centificate has been since	or, page 2	e Completed	25. Was case referred to medical				101		prior to death?	topsy lindings available completion of cause of 2 No
Physici	al direc	70 B	examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatient	3□ DOA Other: 4□1	ce of Death Check of Nursing Home 52		6 ☐Other (Spec	city)
Attending Physicien: ir death.	the funer	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Ye		28c. Injury at Work? M 1 ☐ Yes 2 [	□No		ury occurred	
To the Hospital or A within 24 hours efter To the Funeral Direct	filled in by		4 Homicide determined	28e. Place of Injury building, etc. (5	Specify)		City o	r Town, Sta	te)	ral Route Number,
he Hos in 24 ho	pletely	edicai	(Check only one)	er: On the basis of example and manner stated	amination and/or inv	occurred at the time, date a estigation, in my opinion, de	and place, and due to eath occurred at the t	the cause(some, date ar	s) and manner as nd place, and due	stated. to the cause(s)
To the within	200		29b. Signature and title of certifier	Mo		29c. License number D29675			ate signed (Month	
			30. Name and addless of person who con Ralph Boccia M	D 6420 F	Rockledg	e Dr. Bethe	esda,Md	20816		
Re	Stat egistra	e ir	Ralph Boccia M 31. Date filed (Month, Day, Year) MAR 1 6 200	328 Registrar's	Signature	(I)	•			

			1 - State State Registrar		artment of Health and rtificate of Death	Mental Hygie	0 17 17 77	10228
	Physici		Decedent's Neme (First, Middle, Last)	SUZANNE B. N	MEGLES	2. Date of Death Month MARCH 1	Day Year	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give street and no		4b. City, Town, or Location of Deat		4c. County of Death	
	Funeral Director		ST. CATHERINE'S NURSII  5. Social Security Number  191-01-5480  6. Sex 1 M 2 X F	NG CENTER  7. Age (In yrs. last birthday,  89  Yrs.	EMMITSBURG  If Under 1 Year If Under 24 Hrs  Months Days Hours Min	(Month, Day, Ye	FREDERICK  9. Birthp Count 1917 Penns	place (State or Foreign
	ehow	or	Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ocation	THE NAME OF THE PARTY OF THE PA		0d. Inside City Limits 1 Yes 2X No
	with the M 3a or 28a-f 1 Le notifi	Directo	Pennsylvahia Washingt 10e. Street and Number 11 Washington Street	on	Cokeburg  10f. Zip Code  15324	10g.	. Citizen of What Coun	
136	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, Ite Medical Evantian must be notified at	by Funeral Director	11. Marital Status 12. Was Dec	orces? 2 3 No ive	Was Decedent of Hispanic Origin? (s If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	can Indian,
21215-0036	within 72 hou ene. then "neture he Medical E	Completed		) (Give	edent's Usual Occupation b kind of work done during most of wo DO NOT use retired)	orking 161	b. Kind of Business/Ind	dustry
Maryland 2	should be filed within od Mental Hygiene. marked other than matic event, the Mental Count, the Mental	To Be Co	8 17. Father's Name (First, Middle, Last) Michael Megles			me (First, Middle, Mai		rnment
Mary	d 2 shou th and M ?7 is mar! traumati		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or R			Code)
Baitimore,	Pages 1 and 2 nent of Health int: if item 27 iry or other tra		Helen M. Megles/ Sister  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	matory or other place)	Date 200	MD 20735 c. Location - City or To	
Dait	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Licensee	0	EXIMe and Address of Facility Francis J. Collin 500 University Bl	s Funeral	Home Inc.	
	Pnysician /Medical Examiner	ıer	Sequentially list conditions.	caused the death. Do not en each line.  (or a valuonsequence of):	ter the mode of dying, such as cardia  Heart Fav  tu Cardiave	c or respiratory arrest,	2 cuti Disease	Approximate Interval Between Onset and Death  3 W 10 Y 10
,00/00,	rtificate be executed ng physicien and as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o(as a consequence of):	10-			20 yrs.
.O. DOX	law requires that the death certific as been signed by the attending pl 2 should be detached for use as i	Physician/M	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to a	death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
	The ate h	Completed	V			24a. Was an autopsy performed 1 Yes 2 N	prior to cor death?	psy findings available inpletion of cause of
ion of vital	Jing Ph Ji. After th funeral	atlon: To Be	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien of Injury oth, Day Year)  28b. Time of Injury	nt 3□ DOA Other: 4 Nursing H	ath (Check only one)  Home 5 Residence 28d. Describe how i	e 6 □Other (Specify injury occurred	/)
DIVISION	i ji te	Certification:	3 Suicide 6 Could not be determined 28e. Plac build	e of Injury - At home, farm, sti ling, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	ot and Number or Rura State)	l Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2/ Medical Examiner: On the and man	e best of my knowledge, deat pasis of examination and/or in the stated.	h occurred at the time, date and place vestigation, in my opinion, death occurred	urred at the time, date	and place, and due to	the cause(s)
	3	M	29b. Signature and title of countier	aualla	29c. License number	J 29d.	3/14/	Day, Year)
			30. Name and address of person who completed cau ALAN CARROLL, M.D.	310 S. SETON		G, MD. 217	27	7.1
	Sta Registr		31, Date filed (Month, Day, Year) MAR 1 6 2007	egistrar's Signature				

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of F			iene eg. No.	07	10229
			Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		GLADYS RACHE	L MILLS				FEB.		2007	11:50 P. <sup>™</sup>
	Examin		4a. Facility Name (If not institution, give KLINE HOSPIC				r Location of Death AIRY	1	4c. County FRI	of Death	СК
	F		5. Social Security Number 6. Se		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign try)
	Funeral Director			□M 21/2 F 92	Yrs.	Months Days	Hours Min.	OCT 24	,1914	Penns	sylvania
	P		Usual Residence of Decedent  10a, State 10b, County	100.0	ity, Town or Lo	nation				10	0d. Inside City Limits
	shov	ក	MD Anne A		Pasader						1 No 2 No
	the N	Director	10e. Street and Number	z wasa		10f. Zip Code		1	log. Citizen of V	What Coun	try?
	3a or		8210 Black Diamo	nd Court		21122	?		U.S.A	. •	
	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. is marked other than "natural", or itema 23a or 28a-f show sumatic event, the Modical Examinational be notified at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No	J.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - America ck, White, e	
Maryland 21215-0036	urai', or	d by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo			Specify	AATTT	
<u>.</u>	"natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Bu	usiness/ind	lustry
7	withir iene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	-7		Dome	stic	Arts
פַ	Hygon other	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle,			
<u>Jar</u>	Menta Menta arkad	To E	John Means				<u> </u>	Elizabet			
Mar	d 2 sho th and the ma treum		19a. Informant's Name/Relationship (7) Barbara G. Mills				and Number or Ru Diamond				21122
<u>6</u>	f Heal		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other pla	ce)	Date	20c. Location -	City or To	wn, State
altimore,	Pages nt: If iry or		1 XBunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State C16	, .		Cem. 02/1	8/2007	Clea	rvi11	Le, PA
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic es		21. Signature of Funeral Service Licen	SOO DCKLUCY	2:	2. Name and Addre Dalla Va P.O. Box	ess of Facility 11e Fune 179, Ev	ral Serv erett, P	ice, In A 15537	ic.	
1			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the decone cause on each line.	ath. Do not en	ter the mode of dyn	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	END STA	26E:	Ischer	nic B	owel 4	is eas	e	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse			ilure +				MOS
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. CACN EXIS		111 ta	ITUIE 7	0 ///	100	-	71105
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ChroNic	Dia	whia					MOS
oʻ	en an		resulting in death) Last	Due to (or as a conse	equence of):		1.00				
8760,	cate be executed physicien and the burial-transit	dlcal	•	Immobil	174	Synd	rome				
9	eath certific ettending p for use as	/Mec	IF FEMALE:	23c. If yes, outcome of preg	nancv				23d Da	te of delive	env.
Вох	eath c	clan	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		1		Day Year
o.	the d by the ached	hys	9 Unknown	9□ Unknown							
S,	ires that the death certific signed by the ettending F d be detached for use as	Completed by Physician/Me	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	Inderlying cause gr	ven in Part I.		bacco use conf es 2□No		ne cause of death?
ord	w requir been si should	eted	sope very rec	yac yac	1.96	00,01,-1		-			psy findings available
Vital Records,	he law e hes t	dmo						24a. Was a autop perfor	med?	prior to cor death?	mpletion of cause of
ta	ician: Th	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only o		10163	2,00110
	Physici this cer al direc	ToB	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Ott	her: 4 Nursing H	lome 5 ☐ Resid	ence 6 NOth	ner (Specif)	y)
Division of	ing PI	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe h	ow injury occur	red	
<u>s</u>	or Attending after death. Director: After in by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be		home farm st		]Yes 2□No	28f. Location (S	treet and Numl	ber or Rura	il Route Number,
<u>≥</u>	s after si Director	Certification:	4 Homicide determined	building, etc. (Spec	cify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	n, State)		
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funersi Director: After this certificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 12 Certifying Ph	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, deal nation and/or in	th occurred at the ti evestigation, in my	ime, date and place opinion, death occu	e, and due to the durred at the time, of	cause(s) and madate and place,	anner as si and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11.11.	16010	29c. Licen:	se number	10	29d. Date signe	ed (Month,	Day, Year)
)	8		· Cellen i	rung	WID	05	4/4	7 1	100	12	2007
	nd		30 Name and address of person who	completed cause of death (It	em 23a) (Type	Print) Hos	e Ave	1-1	FREDE	Rick	Mairo
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	11000		1 / /			), (5, )
	Regist		MAR 0 9 20	107	13 1	moth ?					

			Please T	ype or Prin					_		-	
		4	For State	State of Ma		epartme <i>Certifica</i>			Mental Hy			
-			State Registrar  1. Decedent's Name (First, Middle, Last)			Certifica	ale oi	Deam	2. Date of D	Reg. No eath	2007	3. Time of Death
Phys	sicia edica	n	Alice Crissey 1						Month MARCH	Da Z		1:49 A <sup>M</sup>
	mine	er	4a. Facility Name (If not institution, give	street and number)				r Location of Death		40	County of Dea	
F			MEMORIAL HOSPITAL  5. Social Security Number   6. Second	7. Age	(In yrs. last birl	hday) If Unc	JMBER] der 1 Year	If Under 24 Hrs.	8. Date of B	irth	9. Bir	thplace (State or Foreign
Fune Direct			174-38-0268	]M 2 <b>X</b> F		Yrs. Month	ns Days	Hours Min.	(Month, 9	ay, Year	26 P	A
and		- H	Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Location						10d. Inside City Limits
Maryli -f sho		ţ	PA Bedford	1	Man	ns Ch	oice					1 □Yes 2 X No
DESILITIOTE, INIGITY ISLICE ALLO-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Initry or Anther trainmatic event it. Medical Examiner must be notified at		Funeral Director	10e. Street and Number			10f.	Zip Code	550		10g. Ci	tizen of What Co	ountry?
sath w		eral	163 Mis Gem Ln	12. Was Decedent E	ever in U.S.	13 Was De			necify Yes or N	0-	14. Race - Ame	erican Indian,
or item		Ē	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?			pecify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		Black, Whi	te, etc.
ours a		d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:						405 1		hite
n 72 h n 72 h n matu		Completed	15. Decedent's Edu (Specify only highest grad			Decedent's U (Give kind of life. DO NO?	sual Occup work done Luse retire	pation during most of wor d)	king	165. F	Kind of Business	/Industry
d withing giene.		E O	Elementary/Secondary (0-12)	College (1-4or 5-	·	memak	er_				wn Hom	e
d be file ental Hy ced other		To Be (	17. Father's Name (First, Middle, Last)  John Paul Crie	5				18. Mother's Nan Golda	ne (First, Middl E. Mi			
ryld hould id Men marke		၉ .	19a. Informant's Name/Relationship (Ty		19b	. Mailing Addr	ess (Street	and Number or Ru				Zip Code)
INICA and 2 s alth an 27 is			John Bumbarg		ı	-		m Ln, M				
es 1 a of Hear		Î	20a. Method of Disposition 1    Burial 2 □ Cremation 3    For a superior of the superior of t	Removal from State		Disposition (/ ry, crematory o			Date		ocation - City or	
Dartimore Dermit. Pages 1 Department of Hi mportant: If iter			4 □ Donation 5 □ Other (Specify)		Mt. O	livet	Cem	etery 3	-7-200	7	Manns	<u>Choice, PA</u> r Funeral
Depai Depai	once.		21. Signature of Funeral Service Licens	Hetin		Hama	1 4 9	Claran	arvey	Η. Η,,	Leigke	r Funeral PA_15545
			23a. Part . Enter the dise is or complishork, or heart failure. List only o	ications that caused	the death. Do						ramari	Approximate Interval Between
Physici	an		Immediate Cause (Final disease or condition	CORONARY								Onset and Death UNKNOWN
/Medic Examir	-		resulting in death)		a consequence	of):						1 MONTH
		e.	if any leading to immediate	Due to (or as a	a consequence	of):						1 MONIH
oe executed cian and cian and	2	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ARTHERSO								UNKNOWN
be exectan a	8	_	resulting in death) Last	Due to (or as	a consequence	of):						
death certificate be attending physicial		Physician/Medica		d			_					
box atth certi	200	M/ne	23b. was decedent pregnant	23c. If yes, outcome 1 Live birth		3 ☐Ectopi	c pregnanc	ey.		ļ	23d. Date of de	elivery Day Year
the dea		/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		5 ☐ Other					WOTHER	Day
that I	detac		Part II. Other significant conditions co	ntributing to death bu	ut not resulting in	n the underlyin	ig cause gi	ven in Part I.	23e. Dio	tobacco	use contribute	to the cause of death?
COLUS w requires been sign		ed by	END STAGE RENAL D	ISEASE					1	]Yes	2 <b>X</b> No 3 □ F	Probably 4 Unknown
an a a	J	Completed	HYPERTENSION			-	-		24a. Wa	opsy	prior to	utopsy findings available completion of cause of
age i i	ğ								1□ Yes	—/ <u>\</u>	death? lo 1 ☐ Ye	
OF VITAL Physician: 1 this certificated director produced to the certificated to the c		o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2□ER/Ou	ıtpatient 3□	DOA Ot	26. Place of Dea her: 4 ☐ Nursing H	•		6 □Other (Sp.	ecify)
	ਰ	T:UC	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day	ry 28b.	Time of njury	28c. Inju		28d. Describe	e how inj	ury occurred	
I or Attending after death. Director: After in by the fundament		catic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of inju	ırv - At home fa	M rm street fac		]Yes 2□No	28f. Location	(Street a	and Number or F	Rural Route Number,
after of Direction A	2	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	, 511554, 121	10.7)			own, Sta		
UNISIO  DIVISIO  Hospital or Attend  24 hours after death.  Funeral Director; A	areny me	Medical C	29a. Certifier (Check only one) 1 Certifying Phy Medical Exam	rsician: To the best of iner: On the basis of and manner sta	f examination ar	e, death occur nd/or investiga	red at the t tion, in my	ime, date and plac opinion, death occ	e, and due to th urred at the tim	ne cause( e, date a	(s) and manner and place, and du	as stated. ue to the cause(s)
To the Hosp within 24 ho To the Fund		Me	29b. Signature and title of certifier	(10/			29c. Licen	se number		29d. D	ate signed (Mor	nth, Day, Year)
			Parson (	100	3		D31	.875		MAR	CH 4, 2	007
No	23		30. Name and address of person who copy of the ROBERT WELIK,				RLANT	). MD	21502			
	Sta		31. Date filed (Month, Day, Year) 201		ar's Signature	Accel	2	,				
Re	gistr	ar	4111.11.	k'		1						

*	Sta	te	Peter Schissler, 31. Date filed (Month, Day, Year) MAR 1 9 2007		500 Greenwa ar's Signature	y Ctr, Di	r. #430	Greenbe	elt, MD.	20770
ł	(3)		30. Name and address of person who			Print)	2780		3/16,	/2007
Tothe	within 24 h	Med	29b. Signature and title of certifier	and manner sta	ned.	29c. License		29d	-/	Ionth, Day, Year)
Hoenite	4 hours Funeral	edical C	29a. Certifier 1 Certifying Phyone) 1 Medical Example 1	ysician: To the best of the basis of and manner sta	of my knowledge, death	occurred at the time vestigation, in my op	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	se(s) and manne e and place, and	er as stated. due to the cause(s)
DIVISION OF	after death.  I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of inju	iry - At home, farm, stre c. (Specify)	M 1 🗆 1	Yes 2 □ No	of. Location (Stree City or Town, S		r Rural Route Number,
v	After this o	은	1 Yes 2 No  27. Manuer of Death 1 Natural 5 Pending	Hospital: 1 Inpatie  28a. Date of Injur (Month, Day		28c. Injury Work	4 Winursing Home v at 28	e 5 Residence  Bd. Describe how		Specify)
		Be	25. Was case referred to medical examiner?	Hospital:		Ort-	26. Place of Death (	1□ Yes 2 C Check only one)	1 □	Yes 2□ No
Recc	cate has bei	Completed						24a. Was an autopsy performe	prior deat	e autopsy findings available to completion of cause of h?
Records,	been signed should be d	by	Part II. Other significant conditions of	oranbung to death bu	at not resulting in the ur	uenying cause give	ain Parti.	1 Tes		te to the cause of death?  Probably 4 Unknown
P.O. Box		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)	on in Part I	23a Did tab	23d. Date of Month	Day Year
	inicate be executed by physician and as the burial-transit	ledical Examiner	resulting in death) Last	cDue to (or as a	a consequence of):		nat			
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	D.	e dement a consequence of):	14				years
1	hysician /Medical Examiner		snock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Failur Due to (or as	e to thru a consequence of):	ve				Interval Between Onset and Death 2 m . Ths
m i	any per		23a. Part1. Enter the disease, or compshock, or heart failure. List only	Forcel plications that caused		512 NW Cr	rain Hwy.	Bowie,	MD. 20	0715 Approximate
Baltimore,	permit. Pages Department of I Important: If Its any injury or or once.		1 Marial 2 ☐ Cremation 3 Maria 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	)	Allegheny		Park 03/	24/2007 all Fune		n Park, PA.
	of Health I Item 27 r other tra		Carol McCall / da		20b. Place of Dispo	Raging E sition (Name of natory or other place		Bowie,	MD. 20 Oc. Location - City	0720 y or Town, State
E 3	z snould and Men is marke raumatic	2	William James Mc  19a. Informant's Name/Relationship (7)		19b. Mailin	g Address (Street a	Eliza Jas and Number or Rural			te, Zip Code)
pu	be filed htal Hyg ed other event, i	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (		,	
121	within iene. <b>the Med</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	non work done of NOT use retired, memaker	luring most of working )	,	Own ho	ome
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland geartment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eted by	3 X Widowed 4 □ Divorced  15. Decedent's Ed (Specify only highest gra	Year or Dates:	16a, Dece	l Yes 2 No	Specify: ation	16	Specify: 6b. Kind of Busine	White ess/Industry
<b>.</b>	rer dea ritems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	Ever in U.S. 13.		spanic Origin? (Spec in, Mexican, Puerto R	ify Yes or No- ican, etc.)		American Indian, Vhite, etc.
4	23a or		11271 Raging Bro	ok Drive		10f. Zip Code	20720	100	USA	t Country :
	the Mar 28a-f sl	Director	MD Prince G	eorge's	Во	wie		100	. Citizen of Wha	1 ☐ Yes 2 No
	yland now at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
- 37 - 4 - 1	Funeral Director		192-03-3403	M 2X F 7. Ag	e (In yrs. last birthday) 87 Yrs.	Months Days	Hours Min	B. Date of Birth (Month, Day, Y	'ear)	Birthplace (State or Foreign Country) ennsylvania
· · · · · · · · · · · · · · · · · · ·			Villa Rosa Home  5. Social Security Number 6. Se	7 40	o (In urn last hirthday)	Mitche If Under 1 Year	ellville	2 Date of Pirth		George's
	/Medic	cal	Anna H. McCa] 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	larch (	Day Ye 200 4c. County of I	
=	. Physici	an	1. Decedent's Name (First, Middle, Las	•			1	Data of Dooth	7 11 11	3. Time of Death
			1 - For State Registrar	Otato of Mic	aryland / Depa <i>Cei</i>	tificate of L			No.O	7 10001

DHMH 17 Rev 1/2001

VITAL RECORDS, P.O. BOX 68/60,		baltimore, maryland 21213-0030			
sician: The law requires that the death certificate be executed	Phy /N Exa	n 72 hours after death with the Maryland	F D		
certificate has been signed by the attending physician and	/sid led am	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	un ire		/1
rector, page 2 should be detached for use as the burial-transit	cia lic in		er ct	vie ar	и́е
	in al er		al or		di

		For State	State	of Marylan		artment of I		d Mental Hy	0000	10000
4 = = =		Registrar     Decedent's Name (First, Middle)	e, Last)		06	Tillicate of	Death	2. Date of De		3. Time of Death
Physic		HEATHER	, ===,	M	IASON			Month MARCH	16, 2007 Year	6:30 A M
/Med Exam		4a. Facility Name (If not institution	n, give street and n			4b. City, Town, o	or Location of D	eath	4c. County of Dear	th
#		13 Ore Mill I	Place			Thurm			Frederi	
Funera		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Vin. (Month, Da	y, Year) Co	hplace (State or Foreign buntry)
Directo		215-54-7627 Usual Residence of Decedent		46	115.			May 2,	1960   Mar	ryland
laryland show		10a. State 10b. County		10c. City	y, Town or Lo	ocation				10d. Inside City Limits
a-f sh	to	Maryland Fre	derick	T	hurmor	ıt				1 <b>X</b> Yes 2□No
or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	ountry?
ath w s 23a nust t	ral		Place		0 140	2178		2 /C===i6: V== == No		ates
ter de Item	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr	Armed F	cedent Ever in U. Forces? 2 X No	.5.	If Yes, specify Cub	oan, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	Black, Whit	
urs af	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, O Year or	Give ~		1 ☐ Yes 2 🂢 No	Specify:		Specify:	White
72 hor	Completed	15. Deceden (Specify only higher	t's Education	f)	16a. Dece	dent's Usual Occu	pation during most of	f workina	16b. Kind of Business	'Industry
ithin ne.	mple	Elementary/Secondary (0-12)	Coilege	(1-4or 5+)		kind of work done DO NOT use retire			Country Coh	1.
filed within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		17. Father's Name (First, Middle,	5+	•	Speci	ial Educa		Name (First, Middle	County Sch	10018
d be f ental h ed of	o Be	Paul	Maso	n			1	ıeline	Benedi	ct
should be and Mental marked o	2	19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street	t and Number o	or Rural Route Numb	er, City or Town, State, a	Zip Code)
5, INIC 1 and 2 Health a tem 27 is		Daniel J. Duran	nko / Son		13 (	Ore Mill	Place /	/ Thurmont	, Maryland	21788
of He fitem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Pernoval from	20b. F	Place of Dispo emetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Location - City or	Town, State
Pages ment of lant: If ite		4 Donation 5 Other (S		B1		4.5		/21/2007	Thurmont,	Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.  Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any		21. Signature of Funeral Service	Licensee	o sear.	)	2. Name and Addr 104 E. Ma			Funeral Hon it, Maryland	
13 数3	č.	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not en	ter the mode of dy	ing, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	2	Lung	Canc	er				Onset and Death 6 months
/Medica Examine		resulting in death)	Due to	o (or as a conseq	uence of):					
LAdillille		Sequentially list conditions, if any, leading to immediate	b	o (or as a conseq	nence of).					
ted nsit	nine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C Due ii	o (or as a conseq	derice oi).					
execunand n and ial-tra	Examiner	that initiated events resulting in death) Last	c	o (or as a conseq	uence of):					
ate be executed hysician and the burial-transit	ica		d							
rtifical ng phy as th		IF FEMALE:	T							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant	1 ☐Live	outcome pf pregna birth 2 Peta	al death 3	⊒Ectopic pregnand	су		23d. Date of de Month	livery Day Year
the at hed for	/sici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pre 9□Unl	gnant at time of d known	leath 5[	Other (specify)				<b>24</b> ,
that the ed by detac		Part II. Other significant condition	ons contributing to	death but not res	ulting in the ι	ınderlying cause gi	iven in Part I.	23e. Did 1	tobacco use contribute t	o the cause of death?
uires uires signo	d by							1 🔯	Yes 2□No 3□P	robably 4 Unknown
w requir s been si should	Completed							24a. Was	an 24b. Were a	utopsy findings available
The la The la te has	dmo					1		— auto perfo 1□ Yes	psy prior to ormed? death? 2∭No 1 ☐ Yes	completion of cause of 2 □ No
lan: rtifica rtor, p	Be C	25. Was case referred to medica	ı				26. Place of	Death (Check only		
hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 [	Inpatient 2		III. JU DON		ing Home 5 🕅 Resi	idence 6 Other (Spe	ecify)
Ing Ph		27. Manner of Death 1 XNatural 5 ☐ Pendir	ng (Mo	te of Injury onth, Day Year)	28b. Time o injury	Wo			how injury occurred	
ttend leath. tor: /	cati	2 ☐ Accident investing 3 ☐ Suicide 6 ☐ Could	not be 280 Pla	ce of injury - At he	ome farm st	M 1 [	Yes 2 No		Street and Number or R	ural Poute Number
To the Hospital or Attendiwithin 24 hours after death.  To the Funeral Director: A completely filled in by the fr	Certification:	4 ☐ Homicide determ	nined 200. Fla	lding, etc. (Special	fy)	reet, ractory, office	•		wn, State)	urai riodie Number,
spital ours neral									e cause(s) and manner a	
ne Ho n 24 h ne Fu				basis of examina anner stated.	ation and/or i	nvestigation, in my	opinion, death	occurred at the time	, date and place, and du	e to the cause(s)
	edic	one)					a a museele a a		Ond Date signed /Mon	
To th within To th	Medical	29b. Signature and title of certifie				29c. Licen				th, Day, Year)
To the within To the comp	Medic	29b. Signature and title of certifie	J. C.	.>_	·	D	45880		March 19,	
To the within to the To the Comp	Medic	29b. Signature and title of certified 30. Name and address of person	who completed ca			D, Print)	45880	.111	March 19,	2007
10	Medic	29b. Signature and title of certified 30. Name and address of person	who completed ca		96 Pic	Print) card Dr.	45880	ville, Mar	March 19,	2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 18 2007 2:00 Paul Sayre Mattingly ÃΜ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1₩ 2□F 579-01-4332 90 October 26, 1916 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45245 Flintlock Court 20636 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Auto Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Hubert Mattingly Edwardina Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Margaret Mattingly / Wife 45245 Flintlock Court, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 23, 2007 Brentwood, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Michaes 23a. Part1. Enter the disease, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC CARDIO NYSPATHY Due to (or as a consequence of): COTION ADMY MITGRY YEARS Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) a No 1 🗌 Yes 1 Hnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

Director

Funeral

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s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medinal Evaninar marry has natural.

Pages 1 permit. Pages Department of I Important: If its any Injury or o

Baltimore, Maryland 21215-0036

and burial-trai as the use for

The law requires that the death certificate be executed attending physician the director, page 2 should this certificate has After t

MATTINGLY

Vital Records, P.O. Box 68760. Division or after death Director: 6 24 hours a e Funeral I To the within 2

Physician/Medical þ Completed Be Certification: To

> State Registrar

bu

6 Could not be determined

MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number DS6096

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

3-19-07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAJBINDER GILL MD POST OFFICE BOX 640 HOLLYWOOD Md 20636

31. Date filed (Month, Day, Year) MAR 1 9 2007

29b. Signature and title of certifier

3 ☐ Suicide

29a, Certifier (Check only one)

4 ☐ Homicide

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0942 March 2007 Hannah Young Morgan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 2, 1934 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Days Hours 1 □ M 2 🖎 F 228-42-6913 72 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show r then "natural", or itams 23a or 28a-f sho the Madical Examiner must be notified at 1 ☐ Yes 2 🖾 No Funeral Director Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10498 Worcester Highway 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Pages 1 and 2 should be filed vitneric of Health and Mental Hygistant: If Itsm 27 is marked other talury or other traumatic syent, ID 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Kenzer S. Young Bessie F. Goswellen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert A. Young (son) 150 Allen Ave., Laurel, Delaware 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or once. 3-20-2007 Cape Henlopen Crem. 4 □ Donation 5 □ Other (Specify) Frankford, DE 21. Signature of Funeral Service 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Peus /Medical Due to (or as a consequence of) Examiner S- pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760 Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown نه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Carolio verelon Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete 2□ No 1 Yes No 1 Yes of Vital Attending Physician: within 24 hours effer death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 Certification; To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 76-28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide ö Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA3 Dorcheler 31. Date filed (Month, Day, Year) MAR 1 9 State Registrar

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** David James McKinley Martin march 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner harles enter ivista 8. Date of Birth (Month, Day, Yea Sept. 20, 9. Birthplace (State or Foreign 5. Social Security Number ). 1942 Maryland **Funeral** Days 1 XM 2 ☐ F 213-42-6760 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland | Charles Hughesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20637 US 6870 Carrico Mill Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Lovine Cornell McKinley Joseph Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6870 Carrico Mill Rd., Hughesville, MD 20637 Janell Martin - Wife 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Trinity Memorial Gdns 3-23-07 Waldorf, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 3035 Old Washington Road 21. Signature of Funeral Service Licenses I Tack A Wilson Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Gastic Carcinoma Immediate Cause (Final months Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Hypertension, Colonal 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ANo 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Year) 5 Pending investigation ospital c. 4 hours after deau... - ral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar

29b. Signature and title of certifier

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Ind Lulon

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

March 16,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:00 PM 2007 Niland, Joseph Francis March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner VA Maryland Health Care
5. Social Security Jumber | 6. Sex | 7. / Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Min 1**☑** M 2□ F Massachusetts May 27, 1933 Director 033-22-0589 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 ☐ Yes ≵ ☐ No Funeral Director Perryville Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number VA Medical Center-Perry Point 21902 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Eyes 2 □ No If Yes, Give Year or Dates: 1962–65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: SpecifWhite Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) Military Officer U.S. Armed Forces 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Monica Riley Joseph Francis Niland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9358 Northgate Road, Laurel, Maryland 20723 19a. Informant's Name/Relationship (Type. Print) Martin Andrew Niland/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of F March 15 Important: If it any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Cther (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. En er the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consquence of): unknown /Medical Examiner ider tension Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner II Diabetes Mellitus Due to (or as a consequence of): Un Known IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown Hodenolymphoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after death 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number +1

State Registrar

31. Date filed (Month, Day, Year) MAR 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dy VA Mary land Health Care System, Perry Point, MOZIGOZ Melecia Santos M.D.

					artment of Health and	Mental Hygie	ne		
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of Death	Reg.			
	Physici /Medio		KATHLEEN	к.	NESSELRODT		0 Year 0 13:00 P M		
	Examir	er	4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS		4b. City, Town, or Location of Deat CUMBERLAND	'n	4c. County of Death  ALLEGANY		
-	Funeral	plan.		(In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign		
شد	Director			'9 Yrs.	Months Days Hours Min.	04/04/192			
	land ow It		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits		
	Mary a-f sh iffed a	tor	PA Bedford	C	learville		1 □ Yes 2 📉 No		
	ith the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?		
	s 23a nust k		455 South Black Valley R		15535		USA		
336	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Evarried Forces?  1 □ Yes 2 ☒ Norried If Yes, Give Year or Dates:	If	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer I ☐ Yes 2☐ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White		
21215-0036	72 hou natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation kind of work done during most of wo.	rkina 16b	. Kind of Business/Industry		
121	within iene. than "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	00 NOT use retired)  Homemaker	Kang	II		
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	Home den Surname)		
<u>ılan</u>	ould be Mental arked o	To Be	Silas K	ifer	Lottie		McCoy		
Maryland	2 should be and Menta Is marked aumatic ev		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and Number or Re				
e, 1	ges 1 and 2 should t of Health and Mer If Item 27 Is marke or other traumatic		Marion W. Nesselrodt / hus	20b. Place of Dispos			ville, PA 15535  Location - City or Town, State		
Baltimore,	Pages nent of I int: If Its iry or o		1  Burial 2  □ Cremation 3  □ Removal from State 4  □ Donation		natory or other place) Cy Christian Cem.				
altil	permit. Page Department of Important: If any Injury or once,		21. Signatur of Fureral Service Licensee				Funeral Home, P.A.		
8	8 8 5 6 8		fiber C. Color		104 Decatur Stree		and, MD 21502		
	Physiclan /Medical Examiner		23a. Pert1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a complete in the		er the mode of dying, such as cardial	A-	Approximate Interval Between Onset and Death		
5		ner	Sequentially list conditions, facily, leading to the nodate cause. Enter Underlying Cause, (Disease or injury)	nutra equations of):					
6	ficate be executed physician and s the burial-transit	Examiner	that initiated events	consequence of):					
68760,	ate be e hysiciar he buri	edical E	d						
Box 68	that the death certific ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □Live birth 2	☐Fetal death 3☐	Ectopic pregnancy		23d. Date of delivery  Month Day Year		
P.O.	the de	ysic	1  Yes 2 No 4 Pregnant at til 9  Unknown 9 Unknown	ne or death 5□	Other (specify)		,		
	The law requires that te has been signed boage 2 should be deta	by	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause given in Part I.		o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🗗 Unknown		
000	ne law re has bee ge 2 shor	Completed				24a. Was an	24b. Were autopsy findings available		
Œ.		Com				autopsy performed 1∐ Yes 2∰			
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Other	th (Check only one)			
ō	g Phys er this eral dii	2	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury at Work?	ome 5 ☐ Residence 28d. Describe how in	6 ☐Other (Specify)		
ion	arth. or: Afte	atio	1.□ Natural 5 □ Pending (Month, Day 1 2 □ Accident investigation	Year) Injury	Work? M 1 ☐ Yes 2 ☐ No				
Division or Vital Records,	or Atterder de Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc.	r - At home, farm, stre (Specify)	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)		
	To the Hospital or Attending Physically within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.		29a. Certifier  (Check only (C	my knowledge, death	occurred at the time, date and place	, and due to the cause	e(s) and manner as stated.		
	the Hin 24	Medical	and manner state	d.					
<b>.</b>			29b. Signature and title of certifier		29c. License number  0 0 0 3 7 2 9 2	290. 0	Date signed (Month, Day, Year)		
	5	ł	30 Name and address of person who completed cause of dea	th (Item 23a) (Type, F	Print)	. 1 '	1		
	nds		Ar. Suni Gupta 62	5 Kent	Cluenye, (	um berl	and Maryland 215		
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	agette p				

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	-	epartment of I Certificate of			ene g. No Dan T	10000
	×	į.	Decedent's Name (First, Middle, Last	t)				2. Date of Death	1 ( ) 1	3. Time of Death
	Physici /Medio		Phyllis Lorrain	ne NOLAND	)			Month	Day Year 19 200	7 12:55 PI
	Examir	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Dea	
		-	1742 Edgewood H:  5. Social Security Number 6. Social Security Number		e Apt. 3	Hagers		O Data of Digit	Washingto	
ala.	Funeral Director		215-26-8659	DM 2∏ F	74 Yı	Months Days		8. Date of Birth (Month, Day, June 29	Year) 1932 Mar	thplace (State or Foreign ountry) y Land
	yland low at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	a-f sh iffed	ioi	Maryland Washing	ton	Hage	rstown				1 □ Yes 2√ No
	or 28	ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a ust b	rai	1742 Edgewood H	ills Circl	e Apt. 3	21740			USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examine; must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	te, etc.
5-0	72 hc 'natu dical	etec	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. D	ecedent's Usual Occu	pation during most of work	ina 1	6b. Kind of Business	/Industry
21215-0036	12 should be filed within in and Mental Hygiene. 7 is marked other than "fraumatic event, the Med	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	+)	Give kind of work done fe. DO NOT use retire Homemaker	•	I .	Her own ho	ome
9	filed Hygi other ent, ti	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	aiden Surname)	
lan	uld be denta rked ric ev	70 B	John H. Ahalt				Florence	e E. Dayn	nude	
Maryland	2 sho and h is ma rauma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town							Zip Code)
	and and n 27 in 27 iner tr		Lisa Marie Grant	- Daug		Manor Driv			ı, Marylan	d 21740
Baltimore,	Pages 1 ment of H tant: If iter fury or ott		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery,	isposition (Name of crematory or other plain itive Ba		-,	oc. Location - City or Largent, W	
Largent   Larg										
68760,	htticate be executed by pricial and as the burial-fransit as the burial-fransit	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the composition of the composition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to (	a consequence of)	otric.	Can			Interval Between Onset and Death,  H MCMHU
O. Box	The law requires that the death certificat te has been signed by the attending phy agge 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	гу		23d. Date of de Month	livery Day Year
rds, P.	quires tha n signed I uld be det	þ	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in th	e underlying cause gi	ven in Part I.	23e. Did toba		the cause of death?
Records,	ysiclan: The law requir ils certificate has been si director, page 2 should	Completed						24a. Was an autopsy perform	ed2 prior to death?	utopsy findings available completion of cause of
ita		BeC	25. Was case referred to medical				26. Place of Death	1 Yes 2		2 □ No
<b>r</b> <	Physician: this certific ral director, i	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	atient 3 DOA Oti	her: 4 Nursing Ho	1	ce 6 □Other (Spe	cifv)
n 0	ng Pl		27. Manner of eath  1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day				28d. Describe how		
Sio	Attending r death. ector: After by the funer	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2□No			
Division or Vital	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of inju building, etc	ry - At home, farm c. <i>(Specify)</i>	, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
_	To the Hospital or Attending Physical within 2 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	Medical Co	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	iner: On the basis of	examination and/	eath occurred at the to or investigation, in my	ime, date and place, opinion, death occurr	and due to the cau	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	orthe orthe	Mec	29b. Signature and title of certifier	and manner sta	./	29c. Licens	se number	290	d. Date signed (Mont	h, Day, Year)
	r>r0		M. IL	1	MI		D 4647	3	March 1	Mane on
	اسدا		30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Ty	pe, Print)	_ 11		1/201/ N 9	0,000
2	1-5			SVM, MD:	1130 r's Signature	OLALC	1. Had	erstou	n m	21740
	Sta Registr		31. Date filed (Month Pay, Year) 20	07 Sz. Tegistra	J. H.	here		7		

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	_	artment of H <i>rtificate of l</i>			giene Reg. No.	7	10239
	Dhysisi		1. Decedent's Name (First, Middle, Last					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Clara Doris	Saunders 1	Valley			03	17 7	2007	8:20PM
	Examin	er	4a. Facility Name (If not institution, give	/	. ,	4b. City, Town, or			4c. County		- 1
			Washington Co. 5. Social Security Number 6. Se				gers tou			AS AIA	lace (State or Foreign
Н	Funeral Director		160-36-3624	The artification	79 Yrs.	Months Days	Hours Min	May 2	y, Year)	Coun	A/PA
	ס		Usual Residence of Decedent				1	indy 2	1,22,		7
	inylan show	_	10a. State 10b. County		ty, Town or L					1	0d. Inside City Limits
	8e-1 s	cto	PA Frankli	<u>n</u>	Mercer						1 ☐ Yes 2 1 No
	with th	直	10e. Street and Number			10f. Zip Code 172	36		10g. Citizen of V USA		ntry?
	eath is 23	era	13505 Buchanan Tra	ALL WEST  12. Was Decedent Ever in U	IS 13	Was Decedent of H		Specify Yes or No		- Americ	an Indian.
39	filed within 72 hours after death with the Maryland Hygiene. vther than "neturel", or Items 23a or 28e-f show ant, the Medical Examinar must be notified at	by Funeral Director	1 □ Never Married 2,2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		ff Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	rto Rican, etc.)	Blac	k, White, Whit	etc.
21215-0036	2 hou	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation	orkina	16b. Kind of Bu	siness/Ind	dustry
2	thin 7	nple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	daning most or wo	nkiig	1		
	ed wi	Co		4		Teacher			Educa		
nd	be fill	Be	17. Father's Name (First, Middle, Last)	D 1 77				me (First, Middle,		Θ)	
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show eny Injury or other treumetic event, the Medical Examinat must be notified at once.	ဥ	Myers  19a. Informant's Name/Relationship (T)	Rockwell	10h Maili	ing Address (Street		arl Doug		State Zin	Codel
Maryland			George L. Nalley/1	• • •		5 Buchana					17236
	1 an Heal Iem 2		20a. Method of Disposition	20b. I	Place of Disco	osition /Name of		Date	20c. Location -		
2	ages ant of it: If if		1 🗷 Burial 2 □ Cremation 3 □ F  `4 □ Donation 5 □ Other (Specify)	temoval from State		matory or other place Cemetery		21/2007	Mercers	burg.	. PA
Baltimore,	mit. F partme oorter / Injur		21. Signature of Funeral Service Licens	_		2. Name and Addres		ininger-			
Ö	Deparent Dep		Colon T. En	es		47 N. Par					
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the deal ne cause on each line.	th. Do not en	ter the mode of dyin	g, such as cardia	ic or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Meter	tite	Color	(inco				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	uence of):					-	
	nted I Insit	i i	cause. Enter Underlying Cause (Disease or injury		,,						
Ć.	cate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
8760,	ite be ysicia ne bur	cal	(	d							
9	ntifica ng ph s as th		IF FEMALE:								
.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3[	□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	e of delive nth	Day Year
s, P	res that signed b be deta	y Pt	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	underlying cause give	en in Part I.	23e. Did t	obacco use contr	ribute to th	ne cause of death?
rds	w require been sig should b							1 🗆 '	Yes 2⊞No	3 🗌 Prob	ably 4 Unknown
Vital Record	ding Physicien: The law re h. After this certificate has ber funeral director, page 2 sho	Completed						24a. Was auto perfo 1 □ Yes	rmed?	leath?	psy findings available mpletion of cause of 2□ No
/ita	Physicien: this certificaral director, I	Be	25. Was case referred to medical examiner?					eath (Check only o			
of \	hysio	ို	1 ☐ Yes 2 7 Mo			nt 3 DOA	er: 4 Nursing	Home 5 Resi			y)
n C	ling F	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ⊟No	28d. Describe	how injury occurr	ed	
<u>s</u>	or Attending after death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm st		163 2 110	28f. Location (	Street and Number	er or Rura	I Route Number.
Division	after after Direct	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)	root, tactory, office		City or To	vn, State)		
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C		sician: To the best of my known on the basis of examination and manner stated.							
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month,	Day, Year)
			muchael	J. notos	L mo	2 04	11667		3.1	9.07	7
<b>9</b>	4-10		30. Name and address of person who c				gmpus	Hagart	own is	12	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 20 2	32. Registrar's Sign.	d. A	frede		J			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician**  $A^{M}$ Eileen Julianna OConnell 14 2007 March 2:20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F 78 133-22-3142 Yrs. JUNE 20 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ✓ Yes 2 ☐ No MD. FREDERICK FREDERICK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? GENESIS LANE USA 21703 5860 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL Nunse 2 YR5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY CARROLL O'CONNELL DENIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 FOREST HILL DRIVE HOWELL, N. J. 07731 PAUL MURRAY (NEPHON) 20a. Method of Disposition 20b. Place of Disposition (Name of Charlety, ordinatory of other blace) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Valnalla New York 3-21-07 NEW YORK 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SARY L. ROWINS FUN. HOME 21. Signature of Funeral Service Licenses 110 WEST SOUTH ST. FREDBEICR MO ZITOI Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as \*\*onsequence of): disease or condition resulting in death) Cawur /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 → HO 3 □ Probably 4 □ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 No Division or Vital Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ٢ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 29a. Certifier

(Check only one)

1-101

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rhaistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dav. Year)

Amended #2, nls, 03/12/07, Allegany Co.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

pariment of nealth and Menta	i myglerie
ertificate of Death	Pag No

1	0	5	8	
	U	1	1.3	

			1 - State Registrar				Cei	tificate of	Death		Reg. No.	UI	10241
	Physici /Medic		1. Decedent's Nam Dorothy N		Last)					2. Date of D Months Mar	rch 08, 2 ch 8,	<del>007</del> •ar 2 <b>007</b>	3. Time of Death 10:32 P
4	Examir		4a. Facility Name Frostburg					4b. City, Town,	or Location of Dea Frostburg			any of Death	n
	Funeral Director		5. Social Security   215-20-68	97	5. Sex 1 ☐ M 2 🗷 F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of B (Month, D Augus	irth 24, Year 1, 16, 1915		nplace (State or Foreig Mand
	f ehow	or	10a. State  Maryland	of Decedent  10b. County  Allega	anv		y, Town or Lo	cation					10d. Inside City Limit
	with the A 3a or 28a-	Direct	10e. Street and Nu	1	lsh Hill			10f. Zip Code 21532-			10g. Citizen U.S.A.	of What Co	untry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It Health and Mental Hygiene. It marked other than "natural", or Itema 23a or 28a-f show other traumatic event. Ite Madical Examiner must be nuithed at	by Funeral Directo		ried 2 Marrie	12. Was De Armed f	20 No	1	Vas Decedent of left Yes, specify Cub	Hispanic Origin? ( pan, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)		Race - Amer Black, White	
21215-0036	filed within 72 ho Hygiene. other than "natur. ent, Ire Medical	Completed	(Spe Elementary/Sec		grade completed	(1-4or 5+)	(Give	lent's Usual Occu kind of work done OO NOT use retire Ouse tech	pation during most of wi ad)	orking	16b. Kind o	f Business/l	
Maryland	ould be filed Mental Hygis arked other atic event, II	To Be C	17. Father's Name Harold G		ast)				18. Mother's Na Leona Le	ume (First, Middle W1S	le, Maiden Sun	пате)	
	s 1 and 2 sho of Health and J item 27 is me other traums		19a. Informant's N	inner	p (Type, Print) frie		273 An	mstrong Av	e. F:	rostburg	Mary	land	21532
Baltimore,	permit. Pages 1 Department of He Important: if iter any injury or oth			☐ Cremation 3 5 ☐ Other (Spe		n State	semetery, cren stburg Me	sition (Name of natory or other pla morial Park . Name and Addro	Ma ess of Facility	Date rch 11, 2007		Mai	ryland
	Physician /Medical Examiner	10	23a. Parti. Enter	art failure. List or (Final on onditions,	a. Due to	caused the deat each line.	h. Do not ent		al Home, 57 ing, such as cardia Ch'sees	ac or respiratory		g, WID 2	Approximate Interval Between Onset and Death
68760,	ertificate be executed ding physician and se as the burial-transit	/Medical Examiner	cause. Enter Und Cause (Disease o that initiated event resulting in death)	erlying r injury is	c	o (or as a conseq							
P.O. Box 6	0 2 2		IF FEMALE: 23b. Was deceded in the past 1; 1 □ Yes 2; 9 □ Unknown	months?	1 ☐ Live	utcome of pregna birth 2  Feta gnant at time of d nown	Ideath 3	Ectopic pregnand Other <i>(specify)</i>	ру		23d.	Date of deliment	very Day Year
	quires that in signed t	ed by P	Part II, Other sign	ificant condition	_	death but not res	ulting in the ur	nderlying cause gi	ven in Part I.		tobacco use c		the cause of death?
of Vital Records,	ysician: The law requires that the death is certificate has been signed by the atter director, page 2 should be detached for u	Completed by Physiclan								24a. Was auto perf 1  Yes	s an 24 opsy formed? 25 40	Ib. Were aut prior to death? 1 \( \sum \text{Yes}	topsy findings available ompletion of cause of
Vita	Physician: rthis certificated ral director.	Be	25. Was case refe examiner?		Hospital:			I Ot		eath (Check only			
Division of	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Certification; To	1 Yes 27.  27. Manner of Dea  1 Natural 2 Accident 3 Suicide	th 5 ☐ Pending investiga 6 ☐ Could no	28a. Date (Mo	e of Injury nth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju Wo M 1	]Yes 2□No	28d. Describe	how injury oc	curred	
Divi	spital or At cours after of neral Directilled in by	al Certif	4  Homicide	determin	Physician: To ti	ne best of my kno	wledge, death	eet, factory, office	ime, date and place	City or To	e cause(s) and	manner as	ral Route Number,
	To the Ho within 24 t To the Fur completely	Medical	(Check only one) 29b. Signature and	2'∐ Medical E	xaminer: On the and ma	basis of examina nner stated.	ition and/or inv	estigation, in my	opinion, death occ	curred at the time	, date and plac	ce, and due	to the cause(s)
	4			1	in	)		D.	21244	r	3/	9/20	207
	WS		30. Name and add	ress of person w	to completed ca	use of death (Iten	n 23a) (Type, 1044U	Print) LERY 5+	Fro	sthur	g, M.	D 2	(532
	Sta Registi		31. Date filed (Mo.	MAR 1 2	2007	registrar's Signa	iture	ande	,				

Registrar DHMH 17 Rev 1/2001

			For State Registrar		aryland / Depa		lealth and M	lental Hygi	_	10242
	A. F. 12. Fr		1. Decedent's Name (First, Middle, La	ast)			2. Date of Death		3. Time of Death	
	Physic /Medi		Huey Wilson Powell	l. Sr.				Month March	n 10, 2007	04:10 P M
	Exami		4a. Facility Name (If not institution, given			4b. City, Town, o	r Location of Death	21343	4c. County of Deat	h
Sal.			Braddock Campus W	MHS			Cumberland		Allegany	
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)
	Director		214-07-3688	1 M 2□ F	87 Yrs.	Months Days	Hours Min.	(Month, Day, 1 July 02,		vland
	DC _		Usual Residence of Decedent						7777	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f.	cto	Maryland Allega	ny	Frostburg					1 Yes 2 □ No
	72 hours after death with the Maryland natural', or items 23a or 28a-1 show distal Examiner must be posified at	Funeral Director	10e. Street and Number 81 East N	Mechanic Street		10f, Zip Code		10	g. Citizen of What Co	untry?
	238 238	la l	Apt. 209			21532-		U	S.A.	
	ems	ne	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto I	city Yes or No-	14. Race - Ame Black, White	
9	or it	F	1 Never Married 2 Married	1 XYes 2 □ N If Yes, Give	0	1 ☐ Yes 2 🛣 No	Specify:	110011, 010.7		a, etc.
8	urai',	d by	3 Widowed 4 Divorced	Year or Dates:	www	2,03 2,4110	Specify.		Specify: Whit	e
21215-0036	72 t	Completed	15. Decedent's E (Specify only highest gr	ducation ade com <i>pleted)</i>	16a. Deced (Give	ient's Usual Occup	ation during most of working	10	6b. Kind of Business/	Industry
2	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5	+)		during most of working)			
7	filed with Hygiene Ither the		8	0	labore	r			onstruction	
nd	tal H doth	Be	17. Father's Name (First, Middle, Last	")			18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>V</u>	should in and Ment	<sup>L</sup>	Joseph W. Powell				Mary Jane	Spiker		
Maryland	d 2 should be filed within 72 hours after death with the Marylan in and Mental Hygiene. It is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exampler must be coulfied at		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	l Route Number, (	City or Town, State, Z	(ip Code)
	C = 14 =	1 3	Huey W. Powell, Jr.	son		addock Estat	tes From	stburg	Maryland	21532
ore	of Heal of Heal fitem 2		20a. Method of Disposition  1 Burial 2 Cremation 3	Demouslane Chair	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	D D	ate 20	c. Location - City or	Town, State
Ĕ	Pages ment of i	١.,	4 □ Donation 5 □ Other (Special		Eckhart Cem		1	14, 2007 Ecl	khart Ma	ryland
Baltimore,	교부분들	1	21. Signature of Funeral Service Lice	peed		. Name and Addre		11111		
Ö	Depa Impo		John IL	Rucit		Durst Funera	l Home, 57 Fr	ost Ave. Fr	ostburg, MD 2	21532
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do not ente					Approximate
	District		shock, or heart failure. List only Immediate Cause (Final	one cause on each iin	e. <b>,</b>					Interval Between Onset and Death
装	Physician // Medical		disease or condition resulting in death)	a. <u>Ca</u>	rdio - p	alma	Nary	arr	251	1/2 days
	Examiner		1	Due to (or as a	consequence of V		1 /	dien	~ ~ ~	
100		6	Sequentially list conditions,	b. Due to (or as a	consequence of):	/ 4"	rery	a13 e	276	years
	red	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	545 15 (5) 45 (	Consequence on.		/			,
_	and I-trar	хап	that initiated events resulting in death) Last	C. Due to /or as a	consequence of):					
760,	te be executed ysicien and ie burial-transit	cal E		200 10 (0. 200	oonooquonoo or,					
87	# × 6		•	d						
x 68	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE:							
Вох	ath c ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth		Ectopic pregnancy			23d. Date of deli	,
	0 0 0	sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown	ime of death 5	Other (specify)			Month	Day Year
P.O.	at the	Phy	9 🗆 Unknown							
	The taw requires that the de ate has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the un	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Ď	w requir been si should	ed	chronic	00571	uctive	pulmo	nory dise	1 ☐ Yes	2 No 3 Pro	obably 4 Onknown
Division of Vital Records,	aw ra as be 2 sho	Completed				•	/	24a. Was an	24b. Were au	topsy findings available ompletion of cause of
ŭ	The lay	E						autopsy	d?   death?	
<u>a</u>		o l	25. Was case referred to medical				26. Place of Death		No 1 □ Yes	2 No
>		0	examiner? 1 🗀 Yes 2 📉 No	Hospital: 1X Inpatier	it 2 ER/Outpatien	t 3 DOA Cthe	0.0		0.770 (2	
o	Phys er this eral di	<b>-</b>	27. Manner of Death	28a. Date of Injur	28b, Time of			8d. Describe how	ce 6 ☐Other (Special Injury occurred	iry)
0	After a	tlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year) Injury	28c. Injun Work	k? Yes 2 ⊡No		,	
isi	Attending r death. sctor: After by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not b	e One Plans of Injur	ry - At home, farm, stre			8f Location (Stree	et and Number or Ru	ral Route Number
Š	after Dire	erti	4 Homicide determined	building, etc	(Specify)	ot, ractory, omco		City or Town,	State)	ar route rumber,
_	pours ours ours filled	0	29a. Certifier Certifying Ph	nysician: To the best o	f mu knowledge, doeth	and the terminal		- d d 4- 4		
	Hos 24 h Fun Fun	edical	(Check only 2 Medical Exar	niner: On the basis of and manner stat	examination and/or inv	estigation, in my op	ne, date and place, a pinion, death occurre	nd due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier	and mailing s(a)	<b>J</b>	29c. License	e number	704	. Date signed (Month	Day Year
							21244			
	2/100		10	/	•	NO	~1 / 1 /		3/11/2	.00/
	> 0 A		30. Name and address of person who Jesus Tav.	M.D. 4	10	Print)	act him	Ma	vuland	21532
	nes		31. Date filed (Month, Day, Year)		Broadwa	ay, ir	OST DAIG	, ma	1 cevier	L133L
	Sta Registr		MAR 1 2 2007	32. Registra	S Signature	Se de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18 2)40 March 2007 Terry Lee PALLADINO Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 7 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Year) Days Yrs Maryland 1941 March Director 66 214-36-1044 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "nature!" any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 📉 No **Funeral Director** Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 17945 Reiff Church Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2**K** No White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education
(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Heavy Equip. Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances LaPole ٥ Paul Edward Palladino Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17945 Reiff Church Road, Hagerstown, Maryland 21740 Dinah K. Palladino - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory 3/19/07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home Van 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Tracheo-esophageal months **Physician** /Medical Due to (or as a consequence of) **Examiner** phagea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of) attending physician Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2NNo certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 20 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, hours after death. within 24 hours a To the Funeral C

06H-2

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. ney 1ha Union

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Elias Justo Pleitez March 16 2007 1:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George County Fort Washington Health & Rehab Center Fort Washington 8. Date of Birth (Month, Day, Year)
July 20,1935 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
El Salvador 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Funeral Days Hours Min. 227-81-4398 71 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28e-f ehow other traumatic event, the Medical Examiner must be notified at Fairfax County 1 ☐ Yes 2X No Virginia Alexandria Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3421 Sunny View Drive 22309 El Salvador or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Specify: Caucasian 1 № Yes 2 No Specify: El Salvador Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming -0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 Jose Maria Pleitez Rogelia Cortez Landaverde ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Pleitez - Daughter 3421 Sunny View Drive Alexandria, VA 22309 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☑Burial 2 ☐ Cremation 3 ☐Removal from State permit. Page Department of Importent: If Mount Comfort Cemetery March 21,2007 Alexandria, VA injury o 5 Other (Specify 4 Donation 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Jefferson Funeral Chapel à Mard 5755 Castlewellan Dr. Alexandria, VA 22315 Approximate Interval Between Abservand Death Part1. Enter the disease, or shock, or heart failure. List plications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on lead line. Immediate Cause (Final disease or condition resulting in death) Physician ordoro Vasa /Medical Due to (orras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): ettending physicien for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 2 1 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1 ☐ Yes 2 40 or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Mangler of Death 1 WNatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Function (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 2007 Physician HELEN TABLER PALMER 16, 2:48 A M March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Homewood at Crumland Farms Frederick 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** Months Days 1 □ M 2√2 F Yrs. 212-24-5624 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 Willow Road 21702 U.S.A. Funeral 12. Was Oecedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ⊉No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: 2 3 Widowed 4 □ Divorced White other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George William Tabler Florence Holliday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum ance. Elizabeth Plumlee / Daughter 16510 Muni Drive, Apple Valley, CA 92307 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 3/17/07 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Buneral Service Licensee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician TrOKE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the ettending physician and irector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 25 No 9 Unknown 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 2 NO Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 28c. Injury at Work? 28a. Oate of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation Natural 1 Yes 2 No М 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29a. Certifier 29b. Signature and Alle di certifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline, III, 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

ΙÜ

21215-0036

Box 68760

P.O.

Records,

Vital

ŏ

Division

31. Date filed (Month, Day, Year) 9 2007

32. Jégistrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ate of Maryland		artment of F <i>rtificate of</i> .		,	giene Reg. No.		10016
	3.8	*	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	1	3. Time of Death
	Physici /Medio		Phyllis Palmer					Month March	19 200	rear 7	11:00P M
	Examir		4a. Facility Name (If not institution, give stree	·		4b. City, Town, o	r Location of Dea	th	4c. County of	Death	
Regard .		ğ., .	St. Mary's Nursing			Leonard			St.		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day	r, rear)	Countr	
	Director		015-18-7456 Usual Residence of Decedent	87	113.			June 3	0 1919  M	assa	chusetts
Vand	at		10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
Mar	a-f sh ified	ģ	Virginia Fairfax	A	lexand	ria					1 ☐ Yes 2 📉 No
th the	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Countr	y?
death with the Maryland	23a ust b		8507 Stable Drive			2230	8		United	Stat	es
er dea	tems ler m	Funeral	A	Vas Decedent Ever in U.S rmed Forces?	3. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race -		Indian,
Saffe Saffe	ori	by F	1 Never Married 2 Married 1  3 Widowed 4 Divorced Y	Yes 2 No Yes, Give ear or Dates:		☐ Yes 2X No	Specify:		Specify:		
Vithin 72 hours after	itural sal Ex		15. Decedent's Education		16a Deced	ent's Usual Occup	ation		16b. Kind of Busi		
<b>1.</b> 27	n "na Medic	Bet	(Specify only highest grade con	npleted)	(Give i	kind of work done of NOT use retired	during most of wo	rking	TOD. KING OF BUSI	ness/mau	stry
N M	al Hygiene. Other than ' vent, the Me	Completed	ciementary/secondary (0-12)	college (1-4or 5+)	Medic	al Techn	ician		Medical		
	al Hy othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)		
/lan	Menta arked atic e	ည	Lewis Benjamin Palme	r			Joseph	ine Augu	sta Spil	Lane	
Mar. d 2 sho	n and Mental H is marked of raumatic eve		19a. Informant's Name/Relationship (Type. F	· ·	19b. Mailin	g Address (Street	and Number or R	ural Route Numbe	r, City or Town, Si	ate, Zip C	ode)
_ 0	± 52 +		Eunice Yellman / Si		8507	Stable I	rive Al				
	or of		20a. Method of Disposition  1  ↑  ■ Burial 2 □ Cremation 3 □ Remove	val from State	ace of Dispos metery, cren	sition (Name of natory or other plac	re)	Date	20c. Location - Ci	ty or Tow	n, State
DAILIMOI permit. Pages	rtant rtant njury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	St.	Cathe						achusetts
Derm Derm	Department of Heal Important: If Item 2 any injury or other once.			101206	ve-	Name and Addres	D.	rinsfield			
14			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca		Do not ente	er the mode of dvin	.ywood Ko	cor respiratory an	irdtown M	-	and 20650
Ph	nysician		Immediate Cause (Final						-1	1	nterval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	Uss Tu	verno		y our	rein	
E	xaminer		Socreptially list conditions h	Due to (or as a conseque	mo:	sepsis					
p	ii.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (ur as a conseque	ence of).						
æcute	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	<u> </u>	umon	~~~				
oor ou, tificate be executed	physician and s the burial-transit			Due to (or as a conseque	ence or);						
ficate	ng phys as the	edical	d	14			<del></del>				
certii	nding Ise as	ĕ.	IF FEMALE: 23b. Was decedent pregnant 23c. If	yes, outcome pf pregnan	icy				22d Date	d alali sam	
death	attendin d for use	Physician/M	in the past 12 months?	Live birth 2 Fetal of Pregnant at time of dea		Ectopic pregnancy Other (specify)			23d. Date of Month		ay Year
; #	by the	hys	9 ☐ Unknown 9	Unknown		,,,,,,					
The law requires that the death cert	signed by the a	by P	Part II. Other significant conditions contribut	ing to death but not result	ting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contrib	ite to the	cause of death?
equire	s been signal							1 🗆 Y	es 2∐No 3	Probab	ly 4 Onknown
aw r	has be ge 2 sh	Completed						24a. Was a		re autops	y findings available letion of cause of
	certificate ha	Son						perfor	med? dea	th?	□ No
cian:	certificate ector, pag	Be (	25. Was case referred to medical examiner?					th (Check only on			
Physi	al di	은	1 ☐ Yes 24 ☐ No Hospit	1   Inpatient 2   E			4 □ Nursing F	lome 5 ☐ Reside		(Specify)	
ding	After the funeral	ioi	1 □ Matural 5 □ Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurred		
Attending Physician:	after death  Director: /	icat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of injury - At hom	ne farm stre		/es 2□No	20f Location (C)	innet and Alicenters	- D 1.	
5 6	after I <b>Dire</b> d in b	Certification:	4 ☐ Homicide determined 20	building, etc. (Specify)	io, iaiii, olio	ot, radiory, omice		City or Town	reet and Number n, State)	or Hurai F	route Number,
Hospital or	_ # <u>F</u> 0		29a. Certifier 1 Certifying Physician	: To the best of my know	ledge, death	occurred at the tim	ne, date and place	e, and due to the c	ause(s) and mann	er as stat	ed.
he Ho	Within 24 h	Medical	(Check only 2 Medical Examiner: C	On the basis of examination of manner stated.	on and/or inve	estigation, in my op	oinion, death occu	irred at the time, d	ate and place, and	due to the	ne cause(s)
0	Com	ž	29b. Signature and title of certifier	IN	MD.	29c. License		2	9d. Date signed (/	Month, Da	y, Year)
()	V , $ $		NI	10.		D	6008	8	03/2	0/0	· +c
	0		30. Name and address of person who complet								
	1/		Rakhi Krishnan, MD.  31. Date filed (Month, Day, Year)	26840 Poin 32. gistrar's Signatu	t Look	out Road	Leonard	town, Ma	ryland 2	0650	
	Stat	e	MAD 9 a 2007	JE. gistiai s Signatu	to A	make 1					

Physici /Medic Examin	al
Funeral Director	

			1 - State Registrar		Ce	rtificate of	Death	F	leg. No. 200	7 10247
	Dhuele	12.	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea		3. Time of Death
	Physic /Medi		Belinda Gayle Po	rco				03		007 12:00 Noo
F	Exami	ner	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of	
			39241 Danielle W	4		Mechani		1.0	St. Ma	<del>-</del>
þ	Funeral Director		5. Social Security Number 6. S 455-88-3958	□M 2KTE	yrs. last birthday Yrs.	Months Days	If Under 24 Hrs Hours Min.		(, Year)	Birthplace (State or Foreign Country)  Cexas
	p.		Usual Residence of Decedent						, 1991   1	
	arylar show d at	<u>_</u>	10a. State 10b. County	100	. City, Town or L	ocation				10d. Inside City Limits
	Ba-f s	Scto	Maryland St. Mary	y's Me	echanics					1 ☐Yes 2XNo
	leath with the Marylar ns 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	s 23s	eral	39241 Danielle Wa	12. Was Decedent Ever	- 110	20659			United S	tates American Indian,
	ter de Item	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	110.5.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	Black,	White, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	3 ☐ Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1 ☐ Yes A No	Specify:		Specify:	White
5-0	72 hc natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	edent's Usual Occup	ation	rkina	16b. Kind of Busi	ness/Industry
7	ithin he.	du	Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done DO NOT use retired				
21	led w lygier her th		47 5 4 4 1 4 4 4 4 4 4 4		Polic	e Communi				
pu	be fil ntal H od otl even	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
7	d Mer narke	ဥ	Burie H. Haney Jr		401 14 11		Ruth Si			
Ma	d2sh thanc !7 Isrr traum		Michael Vincent E			ing Address (Street				
	1 and Healt em 2		20a, Method of Disposition			I Dan1eII osition (Name of	e Way Me	chanicsv	ille, Ma 20c. Location - Ci	ryland 20659
Baltimore,	ages int of t: If it		15☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom State		osition (Name of ematory or other place	1			
Ħ	artme		21. Signature of Funeral Service Licen		enterpo	int Baptis	st 03/2	23/2007 V	Veatheric	ord, Texas Funeral Home
Ba	permi Depar Impor any ir		Kyle S. Simons	77/2	3	0195 Thre	e Notch	Road Cha	-Ecnois riotto U	funeral Home all MD 20622
			23a. Part1. Enter the disease, or comp	olications that caused the						Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	( )-	o allo	0	0.01	, ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cor		- Can	cer			
	Examiner				,					ļ
100		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
	cuted nd ransi	Examiner	lilat illitiated events	C						
0	e exe ian ar ırial-t		resulting in death) Last	Due to (or as a con	sequence of):					
68760,	ate b hysic the bi	Medical		d						
Ø	eath certificate be executed attending physician and for use as the burial-transit	Mec	IF FEMALE:							
Box	ath o	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐	Fetal death 3	⊒Ectopic pregnancy	/		23d. Date of Month	
	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician.	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify)			Mont	T Day Teal
P.0	that the de led by the a detached		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	ınderiving cause giv	en in Part I	23e Did to	hacco use contribu	ute to the cause of death?
ds,	uires tha signed   d be det	l by						1 □ Y		☐ Probably 4 ☐ Unknown
Ö		Completed								
Rec	2 8 2	dω						24a. Was a autops perfor	n 24b. We sy prid med? dea	ere autopsy findings available or to completion of cause of ath?
B			25. Was case referred to medical					1□ Yes	2 200 1	Yes 2□No
Ξ		Be C	examiner?	Hospital: 1 ☐ inpatient	2 □ ER/Outpatie	nt 3□ DOA Oth		ath (Check only or		
Division or Vital Records,	<b>ਰ</b> ≑ ਫ਼	1: To	27. Manner of Death	28a. Date of Injury	28b. Time o	III JU DOX I	4 Li Nursing F		ence 6 Other	
ion	Attending r death. ector: After by the funer	tior	1 Accident 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury		k? Yes 2 □ No		, ,	
Vis.	or Attendafter death. Director: /	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A	At home, farm, st	reet, factory, office		28f. Location (S	treet and Number	or Rural Route Number,
	s after al Direction by	Certification:	4 Hornioide	building, etc. (Sp	ecity)			City or Town	n, State)	
	ospit hours uners		29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exar	knowledge, deat	th occurred at the tir	me, date and place	e, and due to the c	ause(s) and mann	ner as stated.
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one)	and manner stated.	auon and/or ir			uned at the time, c	ate and place, an	a due to the cause(s)
	Vitt To To	Σ	29b. Signature and title of certifier	- 0 1	,	29c. Licens			9d. Date signed (	Month, Day, Year)
	0					MC	055	101	344	-01
10	Salv			completed cause of death (						
			Jennife 31. Date filed (Month, Day, Year)	r Schmidt Le			and 2065	U		
	Sta Registi		MAR 2 1 2	109	S A	and a				
	- ilogisti	a.,	MILLIN OT C	No.	- 0 /					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 9

32. Registrar's Signature

Rafaela Robles

Date

1500 Forest Glen Rd. Silver Spring, Md 20910

3/24/2007

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906

14337 Georgia Avenue #T-1 Silver Spring, Md

20c. Location - City or Town, State

Honduras

San Pedro Sula,

with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heelth and Mental Hygiana.
ant: if Item 27 is marked other than "naturel", or Items 23e or 28a-1 ehow ury or other treumatic event, the Medical Examinat must be notified as Baltimore, Maryland 21215-0036 permit. Pages to Department of Himportant: if Ite eny injury or ot once.

**Physician** 

/Medical

Examiner

none

10a State

MD

Director

Funerai

Completed by

Be

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unobtainable

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print) Joel Euceda/Son

4 □ Donation 5 □ Other (Specify)

1 Burial 2 □ Cremation 3 ☑Removal from State

**Funeral** 

Director

**Physician** /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit signed by the a d be detached f cartificate has birector, page 2 s After within 24 hours after deeth To the Funstal Director: completely filled in by the

Division of Vital Records, P.O. Box 68760.

	21. Signature Whyneral Service Licens	enft \	924	meand Address of Facility LIP D.RINALD 1 Columbia B	lvd.Silv	er Spri	ng,Md20910	
	23a. Part f. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. aSevere ser	osis	e mode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death	
		Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	olecyst	itis				
-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23d. Date of de Month	elivery Day Year					
1 60000	Part II. Other significant conditions co Chronic kidney				23e. Did tobacco use contribute to the cause  1  Yes 2 No 3 Probably 4			
1	Deep veinous Type II Diabe		.s		24a. Was an autopsy perform	ed? prior to death?	autopsy findings available completion of cause of	
,	25. Was case referred to medical			26. Place of De	ath (Check only one	)		
5	examiner? 1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient 3	Othor			ecify)	
all of the	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	v injury occurred		
A LINE	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street,	factory, office	28f. Location (Str. City or Town	eet and Number or F State)	Rural Route Number,	
GICAL				urred at the time, date and plac gation, in my opinion, death occ				
Ξ	29b. Signature and title of certifier A	177112		29c. License number	29	29d. Date signed (Month, Day, Year)		
	· UM	WWW m	1)	DR63579		March	14,2007	

20b. Place of Disposition (Name of cametery, crematory or other place)

Cemeterio LaPuerta

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

Maria J. Tayaq

MAR 1 6 2007

31. Date filed (Month, Day, Year)

			Please I	ype or Print i				-	_	bie.	
			1 _ For State	State of Mary	•	artment of I <i>rtificate of</i>				7	10250
			Registrar  1. Decedent's Name (First, Middle, Last)		Ce	runcate of	Dealli	2. Date of Dea	th		3. Time of Death
	nysici		LARRY EUGENE REN					Month MARCH	16 200	Year 7	7:00 A M
	/Medic xamin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County of Death		
			618 NORTH MAIN STE	REET		BO	OONSBORO		W	ASHII	NGTON
	neral		5. Social Security Number 6. Sec	IM 2DE	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	1	9. Birthp	place (State or Foreign ntry)
Dire	ector		219-54-0109 'X	59	Yrs.			FEB. 25	, 1948	MAF	RYLAND
yland	Til.		10a. State 10b. County	10	c. City, Town or Le	ocation				1	10d. Inside City Limits
e Mar		ctor	MARYLAND WASHING	ON		B00	ONSBORO				1 ▼ Yes 2 No
dith th	2 2 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
after death with the Maryland or Items 23s or 28s,6 show	rust	Funeral Director	618 NORTH MAIN STE	REET  12. Was Decedent Ever	in II C 12	Mac Deceded of	21713	a situ Van as Na		U.S./	A .
fter de	T No.	Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 No			Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)	Blac	k, White,	
DOORS a	Exan	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify	· WH	HITE
If YIGHTO Z I Z I D-UUDO should be filed within 72 hours after death with the Marylar of Mental Hygiene 72 not forme 72 not 28e4 show	ficel	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give	dent's Usual Occu kind of work done	during most of world	king	16b. Kind of Bu		
within ane.	W We	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	-,		ODEDIT	0.4.0.0	0040404
filed A	ant, #		17. Father's Name (First, Middle, Last)		F1	RAUD SPEC	18. Mother's Nam	e (First, Middle,			O COMPANY
yidili ould be Mental	ic eve	To Be	HARLAN EUGENE REN	INER			PAULINE	LOUISE	SPICKLE	R	
D " = 0	8 3	-	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Stree	t and Number or Ru				Code)
permit. Pages 1 and 2 Department of Health a	item 2.1 is itemed outer their incluins, or femalize roads sure other treumatic event, the Medical Extrin at miss be rediffed at		TERRA L. SEMLER/C				R AVENUE		TOWN, M	ARYL/	AND 21740
ges 1	or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ B	emoval from State	Ob. Place of Dispo cemetery, crea	sition (Name of matory or other pla	ice)	Date	20c. Location -	City or To	own, State
Dallillo bermit. Pages Department of	njury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fune all Service License	)	Rose Hil	1 Cemete	rv   3/19	/2007	HAGERST	OWN,	MARYLAND
Depa	any ir		Arra VIII	Paul M.	Dean B	AST FUNE	DAI HOME	7606 Old Boonsbor			
180			23a. Pari 1. Enter the discass, of dompli	cations that caused the ne cause on each line.	death. Do not en	er the mode of dy				Tanu	Approximate Interval Between
Physi	ician		shock, or heart failure. If only or immediate Cause (Final disease or condition	CC Sum of	d one	unoula					Onset and Death
/Med	dical		resulting in death)	Due to (or as a co							
Exam	imer	_	Sequentially list conditions.	)							
pe	nsit	nine	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury	Due to (or as a co	nsequence or):						
ou, be executed	paramanananananananananananananananananan	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
ite be ex	ne bur	cai		l							
artifica ind ph	should be detached for use as the	Physician/Medi	IF FEMALE:								
ath ce	or us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of portion 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnand	ÿ		23d. Dat Mo	e of delive nth	ery Day Year
) a a	ched	ysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown	ordeath 5t	Other (specify) _					
s that	e deta		Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use cont	ibute to th	he cause of death?
OLUS, requires I	uld be	ed b	cerebral vasiula	accident	with	right 1	em, pleju	L 1□Y	es 20No	3 🗌 Prob	pably 4 Unknown
a w re	2 sho	Completed by	and aphasia by	pertension	a, est.	ma de	mentia	24a. Was a autops		Vere auto	psy findings available mpletion of cause of
The The	page	Com	' ' '	¥	,	/	•	perfor	med?   d	leath?	
Physicien: The lav	ector,	Be	25. Was case referred to medical examiner?	lospital:		0*	26. Place of Dear				
2 g g	raldi	. To	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Inpatient 28a. Date of Injury	2 ER/Outpatier	IL SEL DOA	4   Nursing re	ome 55 Residence 28d. Describe he			V)
nding ath.	e fune	ation	Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injury	f 28c. Inju Wo M 1	ork? ]Yes 2 □No				
r Atte	by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		28f. Location (S City or Town		er or Rura	al Route Number,
itel o	led in			,		· <u>·</u>					
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.	completely filled in by the funeral director, page 2	edicai		eicien: To the best of my ner: On the basis of exa and manner stated.							
To the	omple	Med	29b. Signature and title of certifier	and mariner stated.		29c. Licen	se number		9d. Date signed		
F > F	J		*			0	16940		03-1	5-22	107
			30. Name and address of person of co	mpleted cause of death	(Item 23a) (Type,	Print)		2 1			0 31740
3H-10	_		W. Er Kistzera, M	0 13421	1 Penn	sylvama	Avenue	Hoge	X8 bun	<u>_</u> ~(	31140
R	Sta egistr		31. Date filed (Month, Day, Year) MAR 2 0 2(	32. Registrar's S	y M. A	and		•			

DHMH 17 Rev 1/2001

		1 - State of M State of M Registrar		artment of Health and N rtificate of Death	Reg	ne 2007	10251	
Physic	ian	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	Day Year	3. Time of Death	
/Medi		Dessie M. Richardson			March	13 2007	6:04 A M	
Exami	ner	4a. Facility Name (If not institution, give street and number	4b. City, Town, or Location of Death  Takoma Park		4c. County of Death  Montgomery			
<u> </u>		Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,			8 Date of Birth	9 Birthr	9. Birthplace (State or Foreign	
Funeral Director		255-36-3227	78 Yrs.	Months Days Hours Min.	(Month, Day, Y Aug. 12,	1928 Ge	eorgia	
aryland show dat	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City					10d. Inside City Limits 1X Yes 2 □ No	
he Mi 8a-f	Director	DC 10e. Street and Number		Washing		. Citizen of What Cour		
with t	٦		TT #1	20011	Tog	United S		
eath	Funeral	5824 Colorado Ave., N 11. Marital Status 12. Was Deceden		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ		
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	Armed Forces  1 □ Never Married 2 □ Married  1 □ Yes 2 □  1 □ Yes 2 □  1 □ Yes 2 □  1 □ Yes Give  Year or Dates	[No	If Yes, specify Cuban, Mexican, Pueric  1 ☐ Yes 2 ☑ No Specify:	Rićan, etc.)	Black, White, Specify:	etc. Black	
"natural	Completed I	15. Decedent's Education (Specify only highest grade completed)	16a, Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		
withir ene.	Ĕ	Elementary/Secondary (0-12) College (1-4or	5+)	Nursing Assistant		Govern	nment	
filed Hygi Sther	ပို	17. Father's Name (First, Middle, Last)	L		e (First, Middle, Ma			
d be ental ked c	To Be	Hildred Thomas Simmons			Georgia Douglas			
shoul M mar	-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code					o Code)	
alth a 27 is		DeAlva Graves/Sister P.O. Box 31714, Capitol Heights, MD 20743						
of He of He rothe		20a. Method of Disposition	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place)m	Date 20	Oc. Location - City or To	own, State	
Page nent c		1∭ Burial 2 □Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other ( <i>Specify)</i>	5		2/2007	Arlington	, VA	
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	i	21. Signature of Juneral Service Licensee			ewart Fu	neral Home E Wash.,	DC 20019	
		23a. Part1. In ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.				t,	Approximate Interval Between Onset and Death	
Physician /Medical	ı	Immediate Dause (Final disease or condition resulting in death)  a. Due to (or as a fonsequence of):  Sequentially list conditions,  b. Attavosculus fix Cardio vasculus disease						
Examiner	١.	Sequentially list conditions, b. Atheroscules tic Cardio Vasculas disease						
p sit	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury						
ecute and trans	xam	that initiated events resulting in death) Last  C						
e be ex	a E	546 10 (6) 4						
physicate physicate	edical	d						
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		2 Fetal death 3[ at time of death 5[	□Ectopic pregnancy □ Other (specify)		23d. Date of delive	rery Day Year	
es that this igned by be detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ 10nknown		
w requires to been signed should be	ted							
The lay	Completed				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 □ No	
Or VICAL Physician: Tripis certifical ral director, p	Be	25. Was case referred to medical examiner?						
Physic rthis co	ြို	1 Yes 2 Nursing Home 5 Residence 6 Other (Specify)						
ing P		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Under the Company of Death  28d. Describe how injury occurred Work?  28d. Describe how injury occurred						
Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 380 Place of i	nium. At home form st	M 1 Yes 2 No	29i Location (Ctra	at and Number of Du	mi Dauto Alumbar	
al or Ai al or Ai a after d	Certification:	3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					ai noute Number,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
To th Mithin To th	Me	29b. Signature and title of certifier	29c. License number	29c. License number 29d.		Date signed (Month, Day, Year)		
		· 6	( MD	D00601	00	03-13-	7	
2 (5)		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)						
S	ate	31. Date filed (Month, Day, Year) 32. Regis	strar's Signature	311001	, , , , , ,	110		
Regis	trar	MAR 19 2001 Barand	s. pour	7				

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature and title of certif

HIJEN N

. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Year) 9

29d. Date signed (Month, Day, Year)

Certificate of Death

1-	For State Registrar
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Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

sician and burial-trans the attending physician P.O. Records. Division or Vital

ROBERT BENEDICT

RIEDEL

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 MARCH 10:15 AM Robert Benedict Riedel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 8, 1933 Birthplace (State or Foreign Country) **Funeral** Months 1 M 2□ F 73 Maryland Director 578-42-8240 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2V No Directo Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3140 Calvert Blvd. USA 20657-4626 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Menhal Hygiene.
Important: If item 27 is marked other than "natural", or iten any injury or other transmet. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Catholic Priest 12 Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert B. Riedel Edna Pulles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\textbf{P.O.} \ \ \, \textbf{Box} \ \ \, \textbf{29260} \quad \textbf{Washington,} \ \ \, \textbf{DC} \ \ \, \textbf{20017}$ 19a. Informant's Name/Relationship (Type. Print) Fr. Joseph Ranieri / Administrator 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March Date 20c. Location - City or Town, State 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph's Cemetery 22, 2007 Johnstown, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part1. Enter the diseased, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Imhosy Hogtes (L Unknow disease or condition resulting in death) Due to (or as a consequence of): 0-0X1C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 7,30 hms potens1 Due to (or as a consequence of): UNKnow n Physician/Medical IF FEMALE: N/A
23b. Was decedent pregnant If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No M/A psis 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? NIA 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural MIA MIA 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide NIA 29a. Certifier to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0065451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr HELEN MBAKWE LEONARDTOWN MARYLAND 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 9 2007 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State o	of Marylan		artment of rtificate o		id Mental H	ygiene Reg. No. 2	07	10254
No. of the last of	Dhuaisi		1. Decedent's Name (First, Middle,	,					2. Date of D	eath	Vear	3. Time of Death
	Physici /Medio		Brenda Patricia						March	12, 200		8:13 A M
150	Examir	er	4a. Facility Name (If not institution, Calvert Memoria					or Location of D Frederi		4c. County		
45	Funeral Director		5. Social Security Number 219–48–2620	i. Sex 1	7. Age (In yrs. 58 -	last birthday) Yrs.	If Under 1 Year Months Day			irth 1948	9. Birthp Coun Viro	lace (State or Foreign
	and www.		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryl a-f sho ified a	tor	Maryland Calver	t	Lu	ısby						1 ☐ Yes 2 No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 11535 San Rafae	1 Road			10f. Zip Code Lusb			10g. Citizen of V United		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	Armed Fo	2 No ive		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☑ N	ıban, Mexican, F	? (Specify Yes or Noverto Rican, etc.)		k, White,	an Indian, etc. nite
Maryland 21215-0036	hin 72 houn e. an "natural Medical Ey	Completed t	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		16a. Deced (Give life. L	fent's Usual Occ kind of work don OO NOT use reti	supation be during most of red)	f working	16b. Kind of Bu	ısiness/Ind	dustry
2	ed wit lygiene ner the it, the	Сош	12		. 101 017	Pet G	roomer			Animal		)
and	d be fill ental H ced oth	Be	17. Father's Name (First, Middle, La Lester Ernest P	· ·					Name (First, Middl gia Irene		ne)	
aryl	should and Me s mark umatic	욘	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Stre	_	or Rural Route Num		State, Zip	Code)
	and 2 lealth a m 27 is		Lindsay B. Russ	ell (Dau				Loop, M	Marion, So			
altimore,	Pages 1 ment of H tant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		State Me	Place of Dispo cemetery, cren tropol	sition (Name of natory or other p itan Cre	ematory	3/15/07	20c. Location -	-	wn, State Virginia
Ball	permit Depari Impori any In		21. Signature of Funeral Service Lie	tt		R		neral H	Iome, P.O		), Lu	sby, MD
岩			23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final							arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		ORONA (or as a consequ		RTERY	DISE	ASE			7 years
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	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence of):						
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8760,	icate be executed physician and s the burial-transit	dical		d								
Division or Vital Records, P.O. Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	1 ☐Live I	tcome pf pregna birth 2 □ Feta nant at time of d own	ıl death 3□	Ectopic pregnar Other <i>(specify)</i>	ncy		23d. Dat	e of delive	ery Day Year
rds, P.	The law requires that the dite has been signed by the lage 2 should be detached	þ	Part II. Other significant condition	_		-	nderlying cause (	given in Part I.				ne cause of death?
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/ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	Handle					Death (Check only			
o	Physi r this c ral dire	ု	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1  28a. Date		ER/Outpatien 28b. Time of	1 SIN DOA		ng Home 5 Res	how injury occurr		/)
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical (	29a. Certifier 1 Tertifying (Check only one)	caminer: On the b	e best of my kno pasis of examina uner stated.	wledge, death tion and/or inv	occurred at the vestigation, in m	time, date and p y opinion, death	place, and due to the	e cause(s) and ma e, date and place, a	nner as st and due to	tated. the cause(s)
	Vith Vith CO	Σ	29b. Signature and title of certifier	- NY				nse number	5	29d. Date signed		
	1	}	30. Name and address of person wh	no completed eco	ea of death (Ite-	1 23a) (Ta		20010		311	+ 1 0	(
	4			EW MY		123a) (Type, 1		USBY r	ND 206	57		
	Sta Registr		31. Date filed (Month, Day, Year)	1 6 2007	Registra s Signa		Soul	,				

		1 - State Registrar		Maryland /	Departme <i>Certifica</i>			and M	lental Hy	rgiene Reg. No.	07	10255
Physici /Medic Examir	cal	Decedent's Name (First, Middle, Las     Aa. Facility Name (If not institution, give Suburban Hospita	Beatr:	ice STAL	4b. Cit	y, Town, o Bethe	r Location o	of Death	2. Date of De Month March	14, 20 4c. Cou	07  Thy of Death	
Funeral Director		5. Social Security Number 6. Se		Age (In yrs. last bi		er 1 Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da Jan . 2	rth		place (State or Fore intry) York
e Maryland a-f show	ctor	10a. State 10b. County Virginia Fairfax		10c. City, Tow	on or Location Fairfax							10d. Inside City Lim
th with th 23a or 28 unt be no	al Dire	10e. Street and Number 3702 Moss Brooke	Court		10f. Z	ip Code 2203	1			10g. Citizen o		•
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Itam 27 is marked other then "natural", or items 23a or 28a-f show other traumatic avent, its Medical Examinet must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 I If Yes, Give Year or Dates	s? X No		edent of H ecify Cuba 2 🖾 No		gin? (Spe , Puerto l	ecify Yes or No Rican, etc.)		ace - Amer lack, White cify: wh	etc.
I within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4a 5+	r 5+)	Decedent's Us (Give kind of w life. DO NOT	ork done d use retired	during most i)	of workii	ng	16b. Kind of	Business/II	ndustry
12 should be filed within h and Mental Hygiene. Fis marked other than "raumatic avent, the Men	To Be C	17. Father's Name (First, Middle, Last)  Isidore Godofs	•				18. Mothe		(First, Middle,	, Maiden Sum		
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permit. Pages 1 an Department of Heal Important: if itam 2 any injury or other <u>once</u> .		21. Signature of Funeral-Se vice Licens  23a. Part 1. Enter he disease, or comp	600			insky	s of Facility Hebr	ew I	Funeral			20012
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. M	ed the death. Do line.  OCAR Is a consequence	DIAL					rrest,		Approximate Interval Between Onset and Death
death certificate be executed by the state of the state o	dical Examiner	Sequentially list conditions, a y leading to knowled cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	SEPS  BENEVA  IN INA  IS a consequence	off:	RAC	7	in	I FEC	7101	υ	
that the death certifica ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  Fetal death at time of death	3 □Ectopic p 5 □ Other (s					1	Pate of deliving	ery Day Year
wiequires mat been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death	but not resulting in	n the underlying	cause give	on in Part I.		1		_	he cause of death? pably 4 □Unkno
ate has b page 2 sl	Completed											psy findings availampletion of cause
	o Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	lospital:	tient 2 ER/Ou	tantinat 200	Othe			(Check only o			
r death. actor: After this by the funeral di	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury 28b. 1		28c. Injury Work	at ? 'es 2 N	2		dence 6 🗆 O		y)
i Pig it	Certification;	3 Suicide 6 Could not be determined	building, e	njury - At home, fa atc. <i>(Specify)</i>				V	City or Tow	n, State)		l Route Number,
24 hours a Funeral I	edical	29a. Certifier 1. ☐ Certifying Phy (Check only one) 2 ☐ Medical Exemi	sician: To the bes ner: On the basis and manner s	of examination and	, death occurred d/or investigation	at the tim i, in my op	e, date and inion, death	place, ai occurre	nd due to the d d at the time, d	cause(s) and n date and place	nanner as s , and due to	ated. the cause(s)
withir 2 To the comp et	Med	29b. Signature and title of certifier	0	mo		C. License	number	124		3/ /		
Sta	te	30. Name and address of person who continued the state of	9715 Mcd 32 Regis	ical Par trar's Signature		<sup>#</sup> 201,	Bock	v111	e, MD		, (	

STALZER, BEATRICE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	.egible.			
State of Maryland / Department of Health and Mental Hygiene		2007	10250	,
Certificate of Death	Rea No	6001	10400	_

		1- For State Registrar		Certific	ate of	Death			Reg	No.	I	1 0 10 0 1
Physicia Medical Exami	an/ ner	Decedent's Name (Firs     Da:	vid Melvin	Sampson,	Jr.			_ N	Date of Death Month Narch 22, 2	Day Year		3 Time of Death 1244 hrs
		4a. Facility Name (if not in 1600 Shady Gro	nstitution, give street and r ve Road	number)	41	c. City, Town, or Rockville	Location of	Death		4c. County of Montgom		
Funeral		5. Social Security Numbe	f 6. <b>S</b> ex	7. Age (In yrs. last birt	hday)	If Under 1 Year		_	Date of Birth	(MM/DD/YYYY)	9. 8irth Foreign	
Director		070-40-1863	1 X M 2 F	58	Yrs.	Months Days	Hours	Min.	3/29/			<sup>ntry)</sup> Georgia
any	}	Usual Residence of Dece 10a. State 10b. 0	dent County	10c. City, Town	or Locatio	n		<u> </u>				10d. Inside City Limits
<b>*</b> .	5	MD. Mo	ontgomery	North	Poto	omac						1 Yes 2 X No
Maryland r 28a-f sho ed at once.	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	at Count	ry?
n with the M ms 23a or 2 be notified	al	14520 Pebb	Lewood Drive	ecedent Ever in U.S.	13 Was	2087 Decedent of His	8 panic Origin	n? ( Specify	v Yes or No-	United		ates an Indian, 8lack,
death v rritem	uneral	1 Never Married 2		Forces?		s, specify Cuban				White,	etc.	
s after	by F	3 Widowed 4	Divorced If Yes, Give Yes	ear		Yes 2 X No		ind of work	done	Specify: 16b. Kind of 8us	B1a	
72 hour "natu	eted	Elementary/Secondary	on (Specify only highest gr. (0-12) College			st of working life.			done	TOD. KING OF OUS	1110337111	uustiy
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	omplete			5+ Se	enior	Vice P	reside	ent		Marriot	t Cc	rporation
15-0 filed v al Hygi ed oth	Be Co	17. Father's Name (First,		C			18.Mother's			aiden Surname)  Jones		
212 ould be J Ments s mark ic even		19a. Informant's Name/Re	id Melvin elationship (Type, Print)	Sampson 19	b. Mailing	Address (Stree	t and Numb			per, City or Town	n, State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Imp. rtant: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		June P. Sam				Pebblewo			orth P	otomac,		
Baltimore, bermit Pages Lar Department of Hee Imp rtant: If ite		1 Burial 2 X Cr	emation 3 Removal	from State cremat	ory or other	er place)					ŕ	
ultim nit Pa artmen rrtant		4 Donation 5 C 21. Signature of Funeral		Metro	22. Na	an Crema ame and Address	atory of Facility	3/29 DeVo	/200/  1    Fune	Alexand ral Hom	<u>ria,</u> e	Virginia
Dep Deprimit		Much	al du	lillen	10 1	East Dee	r Par	k Dr.	, Gai	thersbur	rg, I	MD. 20877
Physician /Medical		23a Part I. Enter the dise failure. List only one				e mode of dying,	such as ca	rdiac or res	spiratory arre	st, shock, or hea	nt	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final or condition resulting in c		idem intoxicat: a consequence of)	10n							
	<u>.</u>	Sequentially list condition if any, leading to immedia		a consequence of):								-
	Examiner	cause. Enter Underlying	Cause				_	0		_		
executed an and al - transit		events resulting in death	) Last — Due to (or as	a consequence of):								
	n/Medical	X UNPENDED	AMENDED AMENDED	27,28a-f, perl	ME, g8	66, 4/5/0	7 TT					
<b>∞</b> ∺ ∞ sl		IF FEMALE: 23b. Was decedent pregn		s, outcome of pregnancy birth	2 Feta	al death 3	Ectopic	pregnancy		23d. Date of o Month	delivery Da	ay Year
Box 6: e death cert the attendii	Physicia	past 12 months?	Unknown	gnant at time of death	=	er (Specify)						
ords, P.O. Box 68'.  w requires that the death certifi s been signed by the attending should be detached for use as it			conditions contributing		ig in the ur	nderlying cause g	given in Par	t I.	23e. Did tol	pacco use contrib	bute to t	he cause of death?
s, P.O ires that t signed by	d by											ably 4 🗸 Unknown
cords law requestables been bas been 2 should	Completed								24a. Was a autops perfor	sy p		opsy findings available ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law requirs after death and Director: After this certificate has been seed in by the funeral director, page 2 should	Com					OG Disease	of Death (	Chaok ank	1 <b>✓</b> Yes 2		✓ Yes	s 2 No
Vital hysician this certi	o Be	25. Was case referred to examiner?	No Hospital: 1	Inpatient 2 ER/C	outpatient		Other <sub>4</sub>	Nursing H		Residence 6	Other:	Scene
of Ving Physiang Physiang After the uneral		27. Manner of Death	28a. Da (Mo	te of Injury hth, Day,Year) 28b.	Time of In		ry at Work?			ow injury occurre	∍d	
ivision or Attend after death Director:	catic	2 Accident	IIIvestigation	3/22/2007 Fno	d 12:4	4 pm	Yes 2 X		unk f. Location (S	treet and Number	er or Rur	al Route Number, City
Division pital or Atten ours after death eral Director: filled in by the	Certification	3 Suicide 6 Homicide	X Could not be determined (Specif			,, (40.0.), 01.100			or Town, St	tate)		Rockville, MD
Hos 24 h Fun ely		29a. Certifier 1 Certi	fying Physician: To the b	pest of my knowledge, de	ath occurr	ed at the time, d	ate and pla	ce, and due	e to the cause	e(s) and manner	as state	d. e cause(s)
To the within 2 To the complet	Medical	one) 2 Medi 29b. Signature and title of	and manne	r stated	ii vesiigati	29c. Licens			o timo, acto t	29d. Date signe		
	=	Tester	WAA	C		O.C.	M.E.			March 23, 2	2007	
-		1	f person who completed ca		11 Dags	Stroct P-1	imera A	4D 2120	1	L		
	tate	Zabiullah Ali, M. 31. Date filed (Month, Da		lical Examiner 1	11 Peni	n Street, Ball	uniore, N	12U	1			
Bonic	tate	MAS	2 7 2007 3	Bullet It	25.12	(R)						

State of Maryland / Department of Health and Mental Hygiene | 10257 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Stephens Helen Clara March 4, 2007 2110 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Allegany WMHS-Braddock Campus Cumberland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Year) 11/06/1916 **Funeral** Months Days Hours Min 1 ☐ M 2 🗓 F Yrs. Director 220-16-2678 90 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at 10d. Inside City Limits MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 530 Greene Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Itam 27 ie marked other then "natural", or Ita 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 X Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Gates Gertrude Redman Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 935 Pinecrest Drive, D-4, Cumberland, MD 21502 Bette Stephens / daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State injury or permit. Page Department ( Important: If any injury or Cumberland Crematory 03/09/2007 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Finat Physician disease or condition resulting in death) Chronic Obstructive Asthma 30 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?

1 Yes 2 XNo Month Day Year 4□Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Heart Disease 1 Tes 2 No 3 Probably 4 ∑Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Congestive Heart Failure Yes 2□ No 1 ☐ Yes 2 🗓 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospitat: 1 ∑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🎇 No 2 ER/Outpatient 3 DOA this 28a. Date of tnjury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending death. M 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the bast of my knowledge, deally occurred at the time, date and place, and due to the cauce(s) and manner as stated.

Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hos To the Fune completely fi (Check only one) and ma å 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 2 D26333 March 5, 2007 3 30. Name and a fress of person who completed cause of death (Item 231) (Type. Print)
Richard G. Schmitt. M.D., 900 Seton Drive, Cumberland, MD nes 21502 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 8 2007 Registrar

		1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F		, ,	iene <sub>eg. No</sub> 0 (	07 10258
Physic		Decedent's Name (First, Middle, Last)     ZETTA SAGER SC.	ARLETT				2. Date of Deat Month MARCH	Day	3. Time of Death 3:29 A. M
/Med Exam		4a. Fecility Name (If not institution, give: W.M.H.S MEMOR		S	4b. City, Town, o			4c. County	
Funera Director		5. Social Security Number 6. Set 212–38–5481	7. Age M 2∏X F	78 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		<sup>Year)</sup> 1928	9. Birthplace (State or Foreign Country) WEST VIRGINIA
Maryland I-f ehow	tor	10a. State 10b. County  MD ALLEGA	NY	10c. City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
th with the 23a or 28s	al Director	10e. Street and Number 1706 HOLLAND STR	EET		10f. Zip Code 21502		11	U.S.A	•
ING 21215-50036  be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23a or 28a-f show event, tre Madical Exemicat must be notilied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? ( an, Mexican, Pue Specity:	Specify Yes or No- rto Rican, etc.)		e - American Indian, k, White, etc. :: WHITE
2 2 2	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		+) (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	ALLEGA	siness/industry ANY COUNTY OF EDUCATION
Maryland 2121 d 2 should be filed within th and Mental Hygiene it i? Is marked other then " treumatic event, its Me.	To Be C	17. Father's Name (First, Middle, Last)  EMORY HURL SAG				18. Mother's Na	me (First, Middle, M E M. LA	faiden Sumam NTZ	θ)
C = 64 P		19a. Informant's Name/Relationship (Ty) CHARLES R. SCARL	•		-		iural Route Number, T, CUMBER		
<b>Baitimore</b> , semit. Pages 1 at Department of Hea Mportant: If Item mortant: If Item my lijury or othe suce.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	1	matory or other place	1			City or Town, State
Baltimori permit. Pages Department of I Important: If Its any Injury or of		21. Signature of Funeral Service Ucense	chuck	M.S.V.C	Name and Address UPCHURCH	ss of Facility FUNERAL	09/2007 L HOME, P. ET, CUMBER	Α.	STONE, MD MD 21502
cate be executed  Examiner  physicien and the burial-transit		23a. Part1. Enter tM disease, or complished to the shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	HYPERTE  Due to (or as a	NSIVE CARE a consequence of): a consequence of): a consequence of):					Approximate Interval Between Onset and Death
the death certificate by the attending phys lached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2√No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 1	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d, Date Mon	e of delivery hth Day Year
gned be de	þ	Part II. Other significant conditions con HYPOTHYROIDISM	tributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.			ibute to the cause of death? 3 ☐ Probably 4 Munknown
The law the has b	Completed						24a. Was ar autops perform 1 Yes 2	piged? d	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2☐ No
- × × 5	To Be	25. Was case referred to medical examiner?  1 XYes 2 No	ospital:	nt 2 XER/Outpatier	it 3 DOA Othe	0.00	ath <i>Check on</i> y one Home 5 ☐ Reside		ar (Specify)
ending Physical Control of Ster this or: After this he funeral di	Certification: 1	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	y 28b. Time of Injury	28c. Injun Work		28d. Describe ho		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the funeral completely filled in by the funeral orestores.	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Str City or Town	eet and Numbe State)	er or Rural Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edicai	(Check only Medical Examir	ician: To the best of er: On the basis of and manner stat	f my knowledge, death examination and/or in- ted.	vestigation, in my of	oinion, death occ	e, and due to the ca urred at the time, da	use(s) and mar te and place, a	nner as stated. and due to the cause(s)
To Twith 18	×	29b. Signature and title of certifier	Mun		29c. License	9/57	25		(Month, Day, Year) 6, 2007
nd	)	30. Name and aderess of person who to Paul Snow, M.D.,	Deputy N	4.E., 124		Street,	Cumberlar	nd, MD	21502
St	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	00/21				

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PM Carolyn SMITH Lee 2007 Narch 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Jan. 23, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 942 Days Hours 65 Maryland 215-42-3340 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Hagerstown 1 Yes 2 No Washington 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21742 U.S.A. 300 Northern Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nursing assistant hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Lewis Smith Myrtle A. Benson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Smith - brother 12 South Walnut Street Apt 706, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland Hagerstown Crematory 2007 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 21. Signature of Euneral Service Licenses 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mysecuraline Infarction disease or condition resulting in death) Due (or as a consequence of): Hyperlipudemin Due to lor as a consequen Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events a consequence of Due to (or as a consequence of): resulting in death) Last Asthma 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🖾 No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🗵 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

requires that the death certificate be executed Box 68760. attending physician for use as the buria P.O. signed by t d be detach Division or Vital Records, aw has certificate director, After this or Attending

Examiner Physician/Medical þ Completed Be 2 Certification:

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event; the Medical Examiner must be notified at anone.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

**Funeral Director** 

Completed by

Be

ို

To the Hospital or Atte within 24 hours after de:

To the Funeral Directo completely filled in by the

Medical

13H-2 State

Heckler Mp 31. Date filed (Mon NAR Y2") 2007 Registrar

29b. Signature and title of certifier

3 ☐ Suicide

29a, Certifier

4 Homicide

6 ☐ Could not be

determined

mo

29c. License number

1 Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21740

D0062647

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24 N. Wulnut Street Haverstown

32. P gistrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - For State Registrar		Maryland / De	-	rtment of tificate of		and M		iene eg. No. 2	007	10260
	Physici	an	Decedent's Name (First, Mid				Sarmi an			2. Date of Dea Month	Day	Year	3. Time of Death
P.	/Medio		Buenaventura  4a Facility Name (If not instituti	Fulgueras	er)	-т	Sammien 4b. City, Town,		of Death	March 15		nty of Death	8:30 A M
	Examir	ıer	4a. Facility Name ( <i>If not instituti</i> 8900 01d Palmer	Road	01/			ashingto				ice Geor	rge's
Ĺ	Funeral Director		5. Social Security Number 579–02–7558	6. Sex 7. 1 ☐ M 2 1 ☐ F	Age (In yrs. last birthd		If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birth July 14,	1916	9. Birthp	place (State or Foreign Puppines
	land		Usual Residence of Decedent  10a. State 10b. Count	by	10c. City, Town or	r Loc	ation					1	10d. Inside City Limits
	a-f sh	tor	Maryland Prince	: George's	Ft. Wa	ash:	ington						1 ☐ Yes 2 🗷 No
	or 284	Direc	10e. Street and Number	_			10f. Zip Code			1	0g. Citizen o	f What Cour	ntry?
	s 23a nust b	eral	8900 Old Palmer Ro			40.14		20744			14.0		ppines
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 Maridowed 4 □ Divorce	If Yes Give	<b>X</b> No I		Yes, specify Cu		gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, cify: Fil	
5-0	72 hc 'natuı dical	eted	15. Decede (Specify only high	ent's Education lest grade completed)	16a. De	ecede	ent's Usual Occi kind of work don O NOT use retir	upation e during mos	t of worki	ing	16b. Kind of	Business/In	dustry
121	within ene. than '	Completed by	Elementary/Secondary (0-12)	College (1-4			10 NOT use retir Taker	ed)				In Home	2
d 2	e filed Il Hygi other ent, t	Be Co	17. Father's Name (First, Middle					1		(First, Middle,		ame)	
ylar	Ments Ments arked aric ev	To E	Eulalio Mus	tar Fulg	ueras			Mari			Caleje ————		
, Maryland	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relation Florangel Sammien	nship <i>(Type. Print)</i> to Liu / Daugh						al Route Number Washingto	n, City or Tow n, Mary	n, State, Zip land	20744 
Baltimore,	ges 1 it of H if iter or oth		20a. Method of Disposition  XX Burial 2 □ Cremation	3 □Removal from St	20b. Place of Di cemetery, St. Mary	ispos crem	sition (Name of natory or other pi	ace)	3/19/		20c. Location	-	
Ë	it. Pa intmen intant: injury		4 ☐ Donation 5 ☐ Other  21. Signature of Furieral Service	(Specify)	St. Pary			:				n, Mary	
Ba	Depar Impo any Ir		It. la	er		61	160 Oxon I	ti11 Roa	d Oxo	orge P. Ka on Hill, M	las rund arvland	eral Ho 2074	
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. LWG CWW CEC  Due to (or as a consequence of):  Sequentially list conditions										Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ite has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):								
P.O. Box (	ires that the death certifica signed by the attending ph be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 XXNo 9 ☐ Unknown		h 2 ☐ Fetal death at at time of death		Ectopic pregnan Other <i>(specify)</i>	су				Date of delive Month	ery Day Year
	w requires that been signed should be det	by	Part II. Other significant condi	tions contributing to deat	th but not resulting in th	e un	derlying cause g	iven in Part I.					he cause of death? pably 4  □Unknown
or Vital Records,		Completed								24a. Was a autops perform	SV	prior to co death?	psy findings available mpletion of cause of 2 No
ΖÏ	Physician: r this certificanal director, I	o Be	25. Was case referred to medic examiner? x 1 ☐ Yes 2 1 No	Hospital:	atient 2 ☐ ER/Outpa	tient	317004 0	thar:		(Check only on		Mb (Oi	
Division or	ling Ph I. After th funeral	Certification: To	27. Manner of Death  1 🗓 Natural  2 ☐ Accident  3 ☐ Suicide  6 ☐ Coult	28a. Date of (Month, tigation		ne of ry	28c. Inj W M 1[	ury at ork? ]Yes 2∏I	No	me 5 🖾 Reside 28d. Describe he	ow injury occ	urred	y) al Route Number,
Div	ital or A	Certi	4 Difformation	building	, etc. (Specify)					City or Town	n, State)		
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medica one)	ing Physician: To the ball Examiner: On the bas and manne	is of examination and/o	leath or inv	estigation, in my	opinion, dea	d place, th occurr	red at the time, o	late and place	e, and due to	o the cause(s)
	5 to 20	2	29b. Signature and title of certil					581	82	2	9d. Date sigr <b>3</b> –		Day, Year) - 2007.
(	186		30. Name and address of person Cecil George MD	•	of death (Item 23a) (Tyl y Center Driv	-		enbelt.	Marv	land 20	770		
	Sta		31. Date filed (Month, Day, Yea		istrar's Signature								
DI	Registr		MAR 1 9 2007	pour D	freed								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 2 Day **Physician** NANCY PAIGE SMITH 2007 05:20 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F Director 11/20/1946 268-42-0028 60 Ohio Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director St. Mary's Lexington Park Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ or Items 23a 45890 Skipjack Drive 20653 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2🌠 No Specify: White Specify: þ 3 ☐ Widowed 4 ☑ Divorced "natural" erthan "natur . It e Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mental Hygiene. 8 College Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked ပ Paul White Smith Emogene Elizabeth Duddington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Heam. nt: If item 27 Is Victoria A. Smith/ Sister 8759 Fairlane Drive, Olmsted Falls, Ohio 44138-2144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Brinsfield-Echols Cr. 03/22/2007 Charlotte Hall, MD Funeral Service 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Sig Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mental **Physician** /Medical Due to (or as a consequence of) **Examiner** dundice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Breast Cancer Examine etastatic The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ension 2 ₺No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Dec. 24a. Was an autopsy certificate 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours af To the Funeral D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 175502 3-21-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manoj Panwala, 37767 Market Drive, Charlotte Hall, Maryland 20622 31. Date filed (Mon AR Ygar)3 32. Registrar's Signature State 2007 Registrar

NANCY

		For	State of M		/ Depa		Health	and M	ental Hyg	giene	) n 7	10000
		Registrar  1. Decedent's Name (First, Middle	e, Last)		0071	incate of	Doain	1	2. Date of Dea	Reg. No. /	JUI	3. Time of Death
Physicia	_	Ro	sezella		Tomli	nson			Month 03	Day 15 07	Year	0514 ™
/Medic Examin	- 4	4a. Facility Name (If not institution	n, give street and number	r)		4b. City, Town,	or Location	of Death		4c. County		0514
		WMHS-Braddoc				Cumber					gany	
Funeral		5. Social Security Number 215-16-4355	6. Sex 7. A	ge (In yrs. las	t birthday)_ Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birtl (Month, Day	r, Year)	Coun	**
Director		Usual Residence of Decedent		84					September	09, 1922	Mar	yland
yland how at		10a. State 10b. County		10c. City,	Town or Loc	ation					10	Od. Inside City Limits
e Ma Ba-f s	cto		neral	Ridg	geley							1 □Yes 2MNo
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Director	10e. Street and Number Rout	te 2, Box 286			10f. Zip Code				10g. Citizen of	What Coun	try?
eath v	Funeral	44 14-14-104-1	12. Was Deceden	t Ever in LLS	13 W	26753-		igin? (Sne	ncify Ves or No-	U.S.A.	e - America	an Indian
fter de r item Iner r	Fun	11. Marital Status  1 ☐ Never Married 2 ☐ Marr	Armed Forces	?		as Decedent of Yes, specify Cul			Rican, etc.)	Bla	ck, White,	
urs a	þ	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dates	:	1	☐ Yes 2 🔀 No	Specify.	:		Specif	<sub>y:</sub> -White	
72 ho 'natur dical	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	Ţ	16a. Decede	ent's Usual Occu ind of work done O NOT use retin	pation during mos	st of worki	ng I	16b. Kind of B		
vithin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or	r 5+)			ed)			1	1	
filed v Hygie ther t		17. Father's Name (First, Middle,	Last)		homer	naker	18. Moth	er's Name	(First. Middle.	homema Maiden Surnar		
d be f ental l ced of	To Be	George W. Durst						a Fauz			,	
shoul nd Me mark	F.	19a. Informant's Name/Relations			19b. Mailing	Address (Stree				r, City or Town,	State, Zip	Code)
and 2 alth a 27 Is		Thomas Tomlinso	n son		16800	Old Loarto	wn Rd	S. Fr	ostburg	Maryl	and	21532
es 1 a of He of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 □ Pamoual from State	20b. Plac	ce of Dispos netery, crem	ition (Name of atory or other pla	ace)	C	ate	20c. Location	City or To	wn, State
Pag ment ant: I		4 □ Donation 5 □ Other (S	pecify)		tburg Me	emorial Par	k	Mar	ch 19, 2007	Frostburg	Mar	yland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	/	1	Name and Addi		-				
e o		23a. Part Enter the disease, or	Aura	and the death		Durst Fune					$MD_{\square}^{2}$	1532 Approximate
Physician /Medical Examiner	-	ck, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or a		DIAL nce of):	INF			, roopinatory at			Interval Between Onset and Death Chours
te be ysicia e bur	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a conseque								
t the death certii	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e pf pregnand 2 ☐ Fetal d at time of dea	eath 3 □l	Ectopic pregnan Other <i>(specify)</i>	су				ite of delive	ry Day Year
w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of the Con	ons contributing to death	,	- ,		iven in Part	l.	23e. Did to			e cause of death? ably 4 □Unknown
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Physer this aral di	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of In	ijury 2	3/Outpatient 8b. Time of	3 □ DOA □	4 ⊔ N			ence 6 Oth	- ' ' '	")
ndlng th. r; Afte e fune	tion	15⊈Natural 5 ☐ Pendir 2 ☐ Accident investi		Day Year)	Injury		orƙ? ⊒Yes 2.⊑	1				
r Atter	Certification:	3 Suicide 6 Could 4 Homicide determ	Zoe. Flace of I	njury - At hom etc. (Specify)	e, farm, stre	et, factory, office		2	28f. Location (S City or Tow	Street and Numb	per or Rura	Route Number,
ital or irs after ral Di	Cer											
the Hosp iin 24 hou the Fune	ledical	(Check only 2 Medical one)	ng Physician: To the bes Examiner: On the basis and manner:	of examinatio		estigation, in my	opinion, de		red at the time,	date and place,	and due to	the cause(s)
To Viith	Σ	29b. Signature and title of certifie	0	Ons	)		1377	4		29d. Date signe		
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nes		1 // 1/2	NGODMD	912	SETT	ON DRI	VE (	Cum	BERLA	tnd m	ARYL	AND 21502
Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 6	2007 32 Regis	strar's Signatur	re Again	offis .						

		For			State	of Mai	ryland						ental H	ygiene	)			
		State Registrar						Cei	tificat	e of L	Death	7		Reg. No	20	07	102	263
Physicia	n	Decedent's Nan	, ,				377		-		7.		2. Date of D Month	Day		Year	3. Time of I	
/Medica	-4	4a. Facility Name (		rnes			F			esse		of Death	March		County of	007	4:45	A <sup>M</sup>
Examine	r P	Freder				-	1		-	eder		or Death				erick		
Funeral		5. Social Security		6. Se	x	_		st birthday)	If Under	1 Year	If Unde		8. Date of E	irth	T	9. Birthpla	ace (State or	Foreign
Director		219-20-20		1	<b>X</b> M 2□ F	7	9	Yrs.	Months	Days	Hours	Min.	May 7,	192	7 1	Mary I	änd	
w w		Usual Residence of	of Decedent 10b. Count	hv			10c. City.	Town or Lo	cation							10	d. Inside City	v l imits
Maryk f sho ied at	0	Maryland		-				rmont									1 XYes	
r 28a- notif	Ulrector	10e. Street and Nu	umber						10f. Zip	Code				10g. Cit	izen of W	hat Count	ry?	
h with		15 Clarl	ke Ave	nue						2178	8				USA			
after death with the Maryland or items 23a or 28a-f show miner must be notified at	Funeral	11. Marital Status			12. Was Dec Armed F	cedent Ev	er in U.S	. 13.	Vas Deced	lent of Hi	ispanic O	rigin? (Spe	cify Yes or N Rican, etc.)	lo-		- America		
s afte	S I	1 ☐ Never Mar 3 ☐ Widowed			If Yes, G	2 No	ww I		I □ Yes		Specify					Whit		
tural al Ex		3 MANIGOMEG	15. Decede		Year or I	Dates:	MM T	16a. Dece	lent's Usua	d Occupa	ation			16b. K		siness/Ind		
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d with	Completed				5+		<u> </u>	Ow1	ner/P	resi	dent			F	ish I	Hatch	ery	
be file	ng ng	17. Father's Name	_	e, Last)		_							(First, Middl	-		,		
2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	2 │	Frederic		/=		Tres	selt			(5)		len		line		yford		
d 2 sh th and th and traun		19a. Informant's N Mary Jane											I Route Num mont,			State, Zip (	Code)	
Health tem 27 other tr	1	20a. Method of Dis					20b. Pla	ace of Dispo	sition (Nan	ne of			ate			City or Tov	vn, State	
Pages nent of int: If Its iry or o		1 🙀 Burial 2 4 □ Donation				n State		metery, crer e Rids				3/18/	2007	Thu	rmont	t, MD		
permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical once.		21. Signature of F					1	_	-				uffer			•	PA	
o m m		1 des	ulife	16				10	)4 E.	Mai	n St	reet	Thurn	ont,	MD 2	21788		
2		23a. Part1. Enter stock, or he	n e disea e, al failure. Li	or compl st only	ications that ne cause on	caused the	he death.	Do not ent	er the mod	e of dyin	ıg, such a	s cardiac o	r respiratory	arrest,			Approximate Interval Betw	/een
Physician		Immedi - Cuse disease or conditi	on	VO	a. An	tu	rer	elri	1	en	nor	uh	use				Onset and D	gath
/Medical Examiner		resulting in death)	,		Due to	(or as a	conseque	ence of):									/	<i>y</i>
- 34-		Sequentially list or	onditions,		Due to	o (or as a	conseque	ence of):										
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the de	ysic	1 ☐ Yes 2 9 ☐ Unknow			4⊟Preg 9⊟Unki	nant at ti nown	me of dea	atn 5L	Other (sp	ec <i>ity)</i>			-				,	
		Part II. Other sign	ificant condi	tions co	ntributing to	death but	not result	ting in the ur	nderlying ca	ause give	en in Part	l.	23e. Dio	tobacco u	ıse contri	bute to the	cause of de	ath?
quires n sign	o Dá	try	rest	es	ria							_	10	Yes 2	U-No	3 ☐ Proba	ıbly 4 ∐Uı	nknown
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	Ş	Post	, , , , , ,	-	11	100	ور						per	opsy formed? 2 ☑ No	d	eath?	pletion of ca 2□ No	use of
certificate rector, pag	D I	25. Was case refe examiner?	erred to medic	-	c na						26. Plac	e of Death	(Check only					
hysic this of	2	1 ☐ Yes 2 ☑				Inpatient		R/Outpatien			4 🗆 🛚 🕦		ne 5□Re				1	
After Anners	5	27. Manner of Dea 1 Natural	5 Pend	ing	28a. Date (Mo	e of Injury nth, Day	Year)	28b. Time of Injury		8c. Injury Work			8d. Describe	how injur	y occurre	ed		
death ctor: / the	<u>8</u>	2 Accident 3 Suicide	6 Could		28e. Plac	e of injur	v - At hom	ne, farm, str	M eet factory		Yes 2		r8f Location	(Street an	d Numbo	r or Ruml	Route Numb	ner
after after I Dire	Cerumcauon,	4 Homicide	deter	mined	build	ding, etc.	(Specify)	,,	,,	,				own, State		or riara	riodio ridiffic	,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	5	29a. Certifier	1 Certify	ing Phy	sician: To th	e best of	my know	ledge, death	occurred	at the tin	ne, date a	and place, a	and due to th	e cause(s)	and mar	nner as sta	ited.	
he Ho in 24 l he Fu pletel	ealcai	(Check only one)	2 Medica	al Exami	ner: On the and ma	basis of e nner state		on and/or in	estigation.	, in my o	pinion, de	eath occurre	ed at the time	e, date and	d place, a	ind due to	the cause(s)	
To t To t com	Ž	29b. Signature and	d title of certif	ier	n /	1	1				e number				, -	(Month, E		
SUL			long	. 8	11	le	Ke	7 111.	2 1	13	04	96		3/	16	120	707	
Office.		30. Name and add	dress of perso	n who co	ompleted cau	ise of dea			Print)	41	64	1 10		/	1	1000	2170	
State		31. Date filed (Mo	nth, Day, Yea	r)	Wel.	Registrar		<i>Pj 30</i> ire	10	10,	911	01/	1110	deri.	16,1	ma	01/0	- /
State Registra	_		MAR			AST	_	K	for a	,								
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DHMH 17 Rev 1/2001

Registrar

MAR 1 9 2007

		,	For State Registrar	State of Ma	ryland / Dep Ce	partment of leartificate of		-	giene Reg. No.	)7	10265
	Discontinu		1. Decedent's Name (First, Middle, La	st)				2. Date of De Month		Year	3. Time of Death
	Physici /Medi		Betty Jean	Thorne				March			8:40 a M
	Examir		4a. Facility Name (If not institution, give	e street and number)			or Location of Dea		4c. County o		
			Calvert County Nu				Frederic		Calve		
н	Funeral		5. Social Security Number 6. S	□M 2187 F	(In yrs, last birthda 70 Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Da			ace (State or Foreign try)
á	Director		579-34-1085 Usual Residence of Decedent		78 Trs.			Sep. 6	1928	Wash	., D.C.
	land bw t		10a. State 10b. County		10c. City, Town or	ocation				1	Od. Inside City Limits
	Mary f sh	호	MD Calvert			Marable De	1-				1 □Yes 2 No
	the 28a notif	rec	MD Calvert  10e. Street and Number			North Be	acn		10g. Citizen of W	hat Coun	try?
	3a ol	Funeral Director	8810 Chesapeake	T.iahthouse	Drive		20714		USA		
	ms 2	era	11. Marital Status			. Was Decedent of I If Yes, specify Cub		Specify Yes or No			
5-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	o	1 ☐ Yes 2 X No		rto Rican, etc.)	Black Specify:	, White, wh	<sub>ite</sub>
Ö	2 ho natur ical l	Completed by	15. Decedent's E	ducation	16a. Dec	edent's Usual Occu	pation	artin a	16b. Kind of Bus	siness/Ind	ustry
218	within 7 ene. than "r he Med	Jple	Elementary/Secondary (0-12)	College (1-4or 5-	-) life	re kind of work done DO NOT use retire	ed)	nking			
2121	filed withi Hygiene. other than ent, the M	5	12		titl	e clerk			auto de	aler	ship
pu	be file	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Na	me (First, Middle,	Maiden Surname	e)	
<u>yla</u>	Ment Ment arkec	၉	Lewis Mason An	derson			Gladys	M. Cro	sman		
Maryland	s 1 and 2 should be filed w f Health and Mental Hygie item 27 Is marked other t other traumatic event, th		19a. Informant's Name/Relationship (	•	1	ling Address (Street					*
	12 # Z		Dolores E. Proulx	, daughter					·	·*	h, MD 2071
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dis cemetery, ci	oosition (Name of ematory or other pla	ice)	Date	20c. Location - 0	City or To	wn, State
<u>Ĕ</u>	Pages ment of H ant: If ite ury or of		4 Donation 5 Other (Special		MD Veter	cans Cemet	tery 03-2	21-2007	Chelten	ham,	MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice			22. Name and Addre Rausch Fur		me, P.A.	, Owings	, MD	20736
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not e	nter the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ATRIA		LUATION					Onset and Death
	Examiner			n CORON		RTERY	DISE	ASC			
- Miles	- 244	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):	re le le le le le le le le le le le le le					
	uted d ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	0							
ď	exec an an rial-tr	EX	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
68760,	ficate be executed physician and s the burial-transit	edical	•	d							
	tifica ng ph as th	ledi									
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3	☐Ectopic pregnanc	У		23d. Date Mon		ry Day Year
	res that signed by be deta		Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contril	bute to th	e cause of death?
or Vital Records,	uires 1 sigr 1d be	d by	DEMENTIA, HI	MORRHA	GIC ST	ROKE		1 🗆 1	∕es 2 No	3 ☐ Prob	ably 4 Unknown
Ö	w require been si should b	Completed	<del></del>					24a. Was	0.4h 1/4	lava auto	a diada a susilable
Bě	has has	ᇤ						autor	osv pr	rere autor for to con eath?	osy findings available npletion of cause of
a	ician: The l certificate ha ector, page							1□ Yes			2 □ No
Ξ	sicial certii recto	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only o			
o	Physician: r this certifica ral director, p	2	1 Yes 25 No 27. Manner of Death	1 ☐ Inpatier		BIII 3 DOA	4 Nursing	Home 5 Resid	dence 6 Other		·)
E C	ding F h. After funera	ioi	1 Natural 5 ☐ Pending	(Month, Day		Wo	rk? ]Yes 2∐No	Zod. Describe i	low injury occurre	a	
Division	ttend death stor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not b		ry - At home, farm, s		] Tes 2 □ NO	29f Location /	Street and Numbe	r or Pum	Pauta Number
Ì	or A after Direction by	rtif	4 ☐ Homicide determined	building, etc		meet, lactory, office		City or Tov		i Ui Huiai	noute Namber,
_	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /		(Check only 2 Medical Exal	nysician: To the best on the basis of	examination and/or	ath occurred at the ti	ime, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and mar date and place, a	ner as st	ated. the cause(s)
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	T ¥ 5 S		Job. Signature and title of certifier	World	MO				3/15	107	
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	5		30. Name and address of person who			Print)	CHITZ?	PR			CICK, MD
			GUNIS A MOO	0 y MD	s Signature	STITIC DE	7 30110 3	10	20	67	8
	Sta Registi	ne ar	31. Date filed (Month, Day, Year) MAR 1	9 2007	Secret S	Souls	•				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Elbert Thatcher Turner 1:26 P March 15, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1**⊠**M 2□ F 213-12-7966 89 1918 West Virginia March 14, Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Maryland Calvert Lusby Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11717 Big Bear Lane 20657 United States "natural", or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Special Agent F.B.I. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Francis Turner Beulah Stafford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice C. Turner (Wife) 11717 Big Bear Ln., Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady Star Sea Cem. 3/21/07 Solomons, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): 5 days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed ebrovasc e OUT the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy pertormed death? 1 ☐ Yes 2 ☐ No 2 No ospital or Attending Physician: Thours after death.
uneral Director: After this certificat
ly filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 16

32. Registr

Kioumarce Yazdani, MD 2555 Solomons Island Rd., Huntingtown, Maryland 20639

29c. License number

801110

29d. Date signed (Month, Day, Year)

			riease			ryland / De					-		_	
			1 - For State Registrar	Otate 0	I IVIC	-		cate of L		IIG IVI		Reg. Na	2007	10267
	T P Burga	de s	Decedent's Name (First, Middle, Las	t)		-					2. Date of Dea	ath		3. Time of Death
	Physici /Medio		Wilbur T. Tayl								Januar		3, 2007	11:40 A <sup>M</sup>
1	Examir	er	4a. Facility Name (If not institution, give			4		City, Town, or					County of Deat	
-	Funeral		Calvert County N 5. Social Security Number 6. Se	x		ter (In yrs. last birth	day) If L	Prince	If Under 24	4 Hrs.	8. Date of Birt	h	Calvert 9. Birt	hplace (State or Foreign
1	Director		404-34-2095	XM 2□F	81	Yı	s. Moi	nths Days	Hours	Min.	Jan . 23	3, 1	925 Ten	nessee
	land ow		Usuaf Residence of Decedent  10a. State 10b. County			10c. City, Town	or Location	1						10d. Inside City Limits
	ath with the Marylan 23e or 28e-f ehow	ctor	MD Calvert (	County		Owing	S							1 ☐ Yes 2 XNo
	or 28	Director	10e. Street and Number					f. Zip Code				10g. Cit	izen of What Co	untry?
	s 23a	eral	8015 Portland Cou	rt 12. Was Dece			10 141 - 1	20736		-0.40	-#. V N		.S.A.	des a feedle
10	fter deal	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	91 11 0.5.	ff Yes	specify Cuba	n, Mexican,	Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White	e, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Indicate than "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event, the Madical Examinar mast be notified at	þ	3 Widowed 4 Divorced	1 XYes If Yes, Gin Year or D	ates:		1 🗆 Y	es 2∏ No	Specify:				Specify.Whi	te
15-(	within 72 h ene. than "natu	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)		(	Give kind (	Usual Occupa of work done of OT use retired	turina most c	of workir	ng	16b. K	ind of Business/	Industry
212	jene.	отр	Elementary/Secondary (0-12)	College (1	I-4or 5+	)		Manag	,			Gr	ocery S	tore
nd	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)	-			oudo	2 Ivanienz		s Name	(First, Middle,			0020
yla	should be and Mental marked o	2	Stephen Taylor					5			enningt			
Mar	C1 c2 - 60		19a. Informant's Name/Relationship (7		`		_						r Town, State, 2	
	s 1 and f Health Item 27 other tr		Vivian L. Taylor 20a. Method of Disposition	(Wife	,	20b. Place of D	isposition	(Name of		D	ata		land 20 ocation - City or	
Baltimore,	permit. Pages Department of I Important: If Ite eny injury or of once.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State	Souther	-	or other place		an. ັ		Dun	kirk, M	aruland
alti	permit. Departmimporta Importa eny inju		21. Signature of Fundat Policy Licent	800		Souther.						L Ho	me Calv	ert, P.A.
8	89 2 2 9		Michael W. Jo				8125	South	ern Ma	aryl	and Bly	٧d.,		, MD 20736
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that one cause on e	aused t	he death. Do no	t enter the	mode of dying	g, such as ca	ardiac o	r respiratory ar	rest,		Approximate fnterval Between Onset and Death
	Physician /Medical		Immediate Cause (Finaf disease or condition resulting in death)	a	1d	Age				_				
	Examiner			Due to	oras a	consequence of	:							
1	D =	ner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a	consequence of	:							
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	105.00.0	consequence of								
760,	eath certificate be executed attending physician and for use as the bunal-transit	cal E			(UI as a	consequence or	•							
68	ifficate g phys as the			d										
Вох	th cert tendin r use	an/M	230. Was decedent pregnant	23c. If yes, out		pregnancy	3∏Ector	oic pregnancy					23d. Date of del	
	The law requires that the death certifica lie has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at ti	me of death		or (specify)					Month	Day Year
, P.O.	that the de led by the detached	y Ph	Part II. Other significant conditions co	ntributing to de	eath but	not resulting in t	ne underly	ing cause give	en in Part I.		23e. Did to	bacco u	use contribute to	the cause of death?
Records,	w requires that been signed be should be det	ed by	Parkinsons (	lisea	Se	-					1 🗆 Y	es 2	□No 3□Pr	obably Saknown
eco	law re as bee 2 sho	Completed	Advanced	Dein	ei	tea					24a. Was a		24b. Were au	topsy findings available completion of cause of
_		Соп	Hypertensio	m							perfor	rmed2	death?	2 No
Vital	ician certifi rector	Be	25. Was case referred to medical examiner?	Hospitat:				Othe	200		(Check only or			
ō	> 0 D	. To	1 Yes 22 No 27. Manner of Death	28a. Date	npatient of fnjury			J DOA	4 IN INUIS		8d. Describe h		6 ☐ Other (Spec	cify)
ion	ath. ath. rr: Afte	atlo	Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day	Year) Inju	iry M	28c. Injury Work 1 🗆 Y	t? Yes 2∐No	0			,	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Place	of Injur	y - At home, farm (Specify)	, street, fa	ctory, office		2	8f. Location (S City or Tow			iral Route Number,
	pital o		29a. Certifier Certifying Phy	roleica - Tartha	h 4 - 4			1 1		-1				
	e Hos 24 hc e Fun letely	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	iner: On the ba	asis of e	xamination and/	or investig	ation, in my op	e, date and pinion, death	occurre	nd due to the d id at the time, d	date and	and manner as place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier					29c. License	number		- 2	29d. Dat	e signed (Monti	n, Day, Year)
•			1 (N/8)	no				)5	857	2	<u> </u>	eine	eary 18	,2007
1	1+1		30. Name and address of person who o	ompleted caus	e of dea	th (Item 23a) (Ty	pe, Print)	wite	310	Priv	no Fin	don	(1/ 01	021/70
	Sta	te	31. Datefiled (Month, Day, Year)	32. R	egistra	Signature	1 KO	SWU	510 1	11//	ce the	Lenc	u M	1 10018
k a	Registr		JAN 2	2 2007	A	seem 1	K K	barles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician  $P^{M}$ Felton Tinsley 8:11 2007 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 17, 1927 Birthplace (State or Foreign Country)
 SC 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1X M 2∏ F 80 251-48-8621 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Director VA Petersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Pace - American Indian, Funeral 2570 Glendale Avenue 23803 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 XYes 2 No Army If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Black Specify ģ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retired Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Irene Tinsley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2570 Glendale Ave., Petersburg, VA 23803
e of Disposition (Name of Date 20c. Location - City or Town, State Soontorn Tinsley/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Minnis Cemetery 3/15/2007 4 Donation 5 Other (Specify) Chesterfield, VA 21. Signatur / Funeral Service (c. ee Lewis N. Watson Funeral Home aland Walson 1618 West Rd., Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the my de of dyi shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co Examine The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the under rlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 1 Tes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has by page 2 s autopsy performed? Yes 2010 certificate | 1□ Yes Division or Vital Hospital or Attending Physician: this certific al director, 25. Was case referre o medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day Year) After thi funeral 27. Man r of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural Accident 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

the To the within 2 not IVA

Nasreen Kango, 7701 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) MAR 1 9 2007 32. Registrar's Signature Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated.

29c. Licenso number

29d. Date signed (Month, Day, Year)

		•	1 - For State Registrar	State of Maryland / I	Department of H Certificate of			ene . N2 0 0 7	10269
	Physicia /Medic	_	Decedent's Name (First, Middle, Las     CATHERINE BAX			2	Date of Death Month MAR 7	Day Year 2007	3. Time of Death  3:10 P
	Examin		4a. Facility Name (If not institution, give NATIONAL NAVAL M	Street and number) IEDICAL CENTER	BET	CHESDA	David Birth	4c. County of Death	OMERY
)Ac	Funeral Director		5. Social Security Number 6. Social Security Number 1 579–13–3428  Usual Residence of Decedent	9x □ M 2只F 25	rthday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yuly 4,	9ar) 9. Birting Court	
	Maryland a-f ehow	tor	10a. State 10b. County  MARYLAND MONTGOM	IERY BETHES					10d. Inside City Limits 1 X Yes 2 □ No
	h with the 23a or 28	al Director	10e. Street and Number 10300 WESTLAKE DR	IVE # 206	10f. Zip Code 20817		10g	. Citizen of What Cou USA	ntry?
036	be filed within 72 hours after deeth with the Maryland by giene. By by giene by deether then "naturel", or feme 23a or 28a-f ehow other then "naturel", or feme 23a or 28a-f ehow event. The Mouleal Examiner must be multiped at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Agned Forces? 1 Mayes 2 □ No 2003— If Yes, Give Year or Dates: 2007	13. Was Decedent of HIF Yes, specify Cub	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: WHI'	, etc.
121	U . C .	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working d)	7	Sb. Kind of Business/Ir	
73	should be filed with nd Mental Hygiene marked other the imatic event, the	To Be C	17. Father's Name (First, Middle, Last)  JOHN STUART BAXTE		THE BEDOEDING	18. Mother's Name ( JOAN DUSS	First, Middle, Ma		
	alth ar 11th ar 27 is r trau		19a. Informant's Name/Relationship (GREGORY C. WOCHOS	( HUSBAND) 1	b. Mailing Address (Street 0300 WESTLAK	E DRIVE #	206 , BE	THESDA, MI	20817
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State ARLING	of Disposition (Name of ary, crematory or other pla TON NATIONA)	L APRIL	2007	C. Location - City or T	
Bal	permit. Departr Imports eny inji		21. Ignature of Funeral Service Licer	Line .	1102 WEST	LLS CHURCH	TTAT TT	S CHIIDCH V	IRGINIA Approximate
	Physician /Medical		23a. Part1. Enter the disease, of comshock, or heart failure. Ust only Immediate Cause (Final disease or condition resulting in death)	a. SARCOMA  Due to (or as a consequence		ng, such as cardiac of	iespiratory arres		Interval Between Onset and Death
30,	cate be executed was physicien and burial-transit site burial-transit	I Examiner	Esquentially list our distors, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence					
.O. Box 68760	law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnand 5 Other (specify)	у		23d. Date of delin	very Day Year
rds, P.	quires that n signed build be det	by	Part II. Other significant conditions of	contributing to death but not resulting	in the underlying cause gr	ven in Part I.	23e. Did toba	icco use contribute to	
I Records,	The ate h	Completed					24a. Was an autopsy performe	prior to c	copsy findings available ompletion of cause of 2 \( \square\$ No
f Vital	ding Physician:  n. After this certific funeral director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 ⊠Inpatient 2 ☐ ER/C	Outpatient 3 DOA	26. Place of Death her: 4 Nursing Hom		ce 6 Other (Spec	ufy)
Division of	Jing After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	( <i>Month, D</i> ay Year) n	Time of Injury Mo	rry at 25 ork? ]Yes 2 □ No	3d. Describe how	v injury occurred	
Divis	i Pate	edical Certification:	3 Suicide 6 Could not be determined		farm, street, factory, office	28	Bf. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	he Hospital n 24 hours he Funerel pletely filled	edical		ny stellar: To the best of my knowled miner: On the basis of examination a and manner stated.					
	To the Within 2 To the	×	29b. Signature and title of certifier	D. C	0.1	se number 02201771 (\		d. Date signed (Month 8 Mar 20	-
	20		30. Name and address of person who	completed cause of death (Item 23a	) (Type, Print) N.	ATIONAL NAV			}
76	St Regist	ate rar	THANH D. HOANG  31. Date filed (Month, Day, Year)  MAR 1 6 2	MC USN 32 egistrar's Signature	Soule	ETHESDA MD	ZU889-5	UUQU	

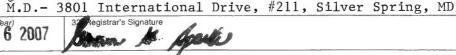
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** 2:40 P M 10, Lawrencine Witherspoon March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3210 Norbeck Road Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 □ M 🛠 🛱 F Nov. 1, 1921 South Carolina 85 Director 578-22-3674 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any ijury or other traumatic event, the Medical Examiner must he provided. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 United States 3210 Norbeck Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Auto and Residential Elementary/Secondary (0-12) 12 College (1-4or 5+) Insurance Agent Industry 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Addie Stuckey Lawrence Caroline P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Saundria Jessup-Daughter 12915 Bluet Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Loudon Park Crematory 3/16/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Er er the disease, or conshock, rineart failure. List on immediate use (Final disease or condition resulting in death) Months Physician Cholangiocarcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. if yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☒ No 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 L Unknown Hypertension Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed' 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home SPResidence 6 Other (Specify) Hospital: 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 38457 March 13, 2007

State Registrar 31. Date filed (Month, Day, Year) MAR 1 6 2007

Nakul Gdya/1,

30. Name and addless of bersoft who completed cause of death (Item 23a) (Type, Print)



/ 1	.3/0/,/		egany Co.	State of Ma		/ Depa		t of H	ealth a				007	10271	
	AN 3		Decedent's Name (First, Middle, Lass	t)							2. Date of Dea			3. Time of Death	
	Physici		MARY TERESA	WINTERS							Month MARCH	Day <b>8</b> ,	2007	11:10 A <sup>M</sup>	
	/Medic	- 101	4a. Facility Name (If not institution, give				4h City	Town or	Location o	f Death	MARCH	- 1	county of De		
	Examin	er	FROSTBURG VILLAG		LOME					. 202					
7 -5 20			5. Social Security Number 6. S		(In yrs. last	birthdav)	If Under	OSTB 1 Year	ff Under a	24 Hrs.	8. Date of Birt	h	ALLEGA 9. B		
	Funeral Director			□ M 2 <b>X</b> F	93	Yrs.	Months	Days	Hours	Min.	(Month, Da) FEB. 3	y, Year)	1 N	irthplace (State or Foreign Country) [ARYLAND	
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	yian		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. fnside City Limits	
	Ma-f.s	Ç	MD ALLEG	ANY	LAV	VALE								1 ☐ Yes 2 ☐ No	
	death with the Maryland ims 23e or 28e-f show i must be notified at	Director	10e. Street and Number	_			10f. Zip	Code				10g. Citiz	en of What (	Country?	
	th wi	aic	927 NATIONAL HIG	HWAY			2	21502	2			Ţ	J.S.A.		
	ems ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	city Yes or No- Rican, etc.)	1-	14. Race - American Indian, Black, White, etc.		
9	afte or it	T.	1 Never Married 2 Married	1 Yes 2 No	0	1	1 ☐ Yes 2		Specify:		, , ,		Specify:		
200	n 72 hours after death with the Marylan "neturel", or Items 23e or 28e-f show idical Examiner must be motified at	d by	3 XWidowed 4 □ Divorced	Year or Dates:								WHITE			
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7	withir ne. ihen	Q.	Elementary/Secondary (0-12)	Coflege (1-4or 5+	+)		DO NOT US CTORY					TION			
7	be filed within 72 hours after death with the Maryla ital Hygien. Id other then "neturel", or items 23e or 28e-f shov event, the Medical Examinet must be notified at		12 17. Father's Name (First, Middle, Last)					. 1101		r'e Name	(First, Middle,			11014	
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Ž	ges 1 and 2 should be to f Health and Menta if item 27 ie marked or other treumatic ev	ဥ	19a. Informant's Name/Relationship (	Type Print)		Ob Mailie	a Addrass	/Stroot a			al Route Numbe	r City or	Town State	Zin Codol	
2	d2 s th an 7 ie r treur		MARY A. BRENNER								OCOMOKE	City		21851	
บ์	s 1 and if Heali item 2 other		20a. Method of Disposition	DAOGITER	_		sition (Nan		OIKEE.		Date			Z1001 or Town, State	
2	Pages nent of I int: if its iry or o		1 XBuriaf 2 ☐ Cremation 3 ☐		ceme	etery, crer	natory or o	ther place	1						
Saltimo	. 도 용 그		4 Donation 5 Other (Specify	-	SUNSE				-		/2007	Ct	JMBERL	AND, MD	
<u> </u>	Depart Depart Import any in		21. Signature of Funeral Service Licen	See /		22	2. Name an UPCH		I FUNI	y ERAL	HOME,	P.A.			
	40.240		yourg y	ap rune									$\mathbb{D}$ , $\mathbb{M}$ D		
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each line	e.	Jo not ent	er the mod	e or ayıng	g, such as	cardiac (	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Finaf disease or condition	a End s	Tage	_	Dem	en	Ha					6 months	
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):									
	- Xummer	_	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):												
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
	and -tran	кап	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):												
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200	physic	dicai		d											
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DOX	ath o	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	2 🗌 Fetaf de	ath 3	Ectopic pr					23	3d. Date of d Month	elivery Day Year	
5	the a	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death	n 5L	Other (sp	ecity)						ŕ	
	hat the d by	P	Part II. Other significant conditions of	ontribution to death bu	t not requitie	a in the u	adorhina o	21100 0840	on in Part I		23a Did to	obacco ue	e contribute	to the cause of death?	
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ပ္	law nesb e 2 si	Completed									24a. Was autop	sy	prior to	autopsy findings available completion of cause of	
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Alla	sicien: The law s certificete hes t irector, page 2 s	Be	25. Was case referred to medical examiner?							of Death	Check only o	ле)			
5	hysi his c	၉	1 ☐ Yes 200 No	Hospitaf: 1 ☐ Inpatier		/Outpatier	nt 3 DC		4AQ NU	rsing Ho	me 5 Resid	dence 6	Other (Sp	pecify)	
_	ng P fler t nera	 	27. Manner of Death  1√ZNatural 5 ☐ Pending	28a. Date of fnjun (Month, Day	y Year) 28	b. Time o	f 2	8c. Injury Work	/ at c?		28d. Describe I	now infury	occurred		
UNISION	eath.	Certification;	2 Accident investigation				М	1 🗆 '	Yes 2 🗆	No					
Ξ	r Att	Ē	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home . <i>(Specify)</i>	, farm, str	reet, factory	r, office			28f. Location (S City or Tox	Street and vn. State)	Number or	Rural Route Number,	
2	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funarel Director: After this cartifoc completely filled in by the funeral director,														
	Hosp 4 hou Funs ely fi	ical	(Check only 2 Medical Exar	ysicien: To the best on the basis of	examination	dge, deat and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the red at the time,	cause(s) a date and	and manner place, and d	as stated. ue to the cause(s)	
	the I	Medical	one)	and manner stat	ted.										
	,		29b. Signature and title of certifier	of .	MD				number					nth, Day, Year)	
	5		· wonsock					POC	0553	525		Ma	ech o	9,2007.	
	ĥ Ω 1		30. Name and address of person who	completed cause of de	eath (Item 23	Ba) (Type,	Print)		Ü		110 - 1	0 -			
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DHMH 17 Rev 1/2001

			For 1 State	State of		d / Depa	artment of H	ealth and N			1 10072			
			Registrar			Cei	tificate of l	<i>Death</i>		g. Nó	10413			
П	Physici	an	1. Decedent's Name (First, Middle Betty	e, Last)	Jean		Welch		2. Date of Death Month	Day Yea				
	/Medic		4a. Facility Name (If not institution	give street and num	nher)			Location of Death		4, 2007 4c. County of D	7:54 P M			
	Examin	er	Country House	_			•	erland	Alleg					
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)			
	Director		220-16-5965	1□M 2XDF	84	Yrs.	Months Days	Hours Min.	(Month, Day, 01/25/19		laryland			
	D s	-	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation		-		10d. Inside City Limits			
	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show the Madical Exeminer rust be notified at	ō		egany	100. 0119,		umberland	l			1X Yes 2 □ No			
	the A	rect	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?			
	3a or		476 Willia	ms Street			,	21502		USA	,			
	death ms 2	nere	11. Marital Status	12. Was Dece	dent Ever in U.S	. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp	pecify Yes or No-		merican Indian,			
9	after or its	F	1 Never Married 2 Marr	Armed For ned 1 ☐ Yes If Yes, Giv			rres, specnny Cuba 1 □ Yes 21∑ No	Specify:	Hican, etc.)	Black, W	hite, etc.			
933	real',	Completed by Funeral Director	3 ₩ Widowed 4 Divorced	Year or Da	ates:		11	Specify:	White					
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Maryland 21215-0036	Jental Jental rked tlc ev	James Watter FileRinger Laura  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route  Cathy Growden / daughter  13300 Ali Ghan Road, NE.,								gina	Kelly			
ary	2 shoil and h									City or Town, Stat	e, Zip Code)			
	and 2 ealth m 27									., Cumberland, MD 2150				
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3 Removal from State														
1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Ashby										Fort As				
20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22b. Place of Disposition (Name of cemetery, crematory or other place)  Fort Ashby Cemetery 03/18/2007 Fort  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Adams Family Funeral Service Licensee  4 Uth Decatur Street, Cumberland,									•					
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	au ed the death. ach line.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between			
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P.0	requires that the een signed by th tould be detache	/ Ph	Part II. Other significant condition	ons contributing to de	eath but not resul	iting in the u	nderfying cause give	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?			
Records,	uires sign	Completed by	Verne	tha!					1 🗆 Ye	s 20 No 3	Probably 4 Unknown			
00		iete							24a. Was an	24b. Were	autopsy findings available			
Re	sicien: The law scertificate has b irector, page 2 s	ошь							autopsy	prior death	to completion of cause of			
Vital	ien: rtifica	Bec	25. Was case referred to medica		(1)			26. Place of Dea	th (Check only one		65 2 10			
f V	> 27 0	ToE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🔲 I	npatient 2 🗆 E	R/Outpatier	it 3 DOA Oth	er: 4 Nursing H	ome 5 🗆 Reside	nce 6 🛣 Other (S	Assisted Decify) Living			
0 _	ng Pt fter th		27. Manner of Death  Natural 5 ☐ Pendir	28a. Date of	of Injury th, Day Year)	28b. Time o Injury		y at	28d. Describe ho					
sio	Attending r death. ector: After by the funer	cati	2 ☐ Accident investi	gation				Yes 2□No						
1   Inpatient   2   ER/Outpatient   3   DOA   Mursing Home   5   Reside   28d. Describe here							eet and Number o State)	Rural Route Number,						
_	Hospital or 24 hours afte Funers! Dir tely filled in I	29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								r as stated				
	To the Hospital or Attending Phwithin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral.	Medical		Examiner: On the ba	asis of examinati	on and/or in	vestigation, in my o	pinion, death occu	rred at the time, da	te and place, and	due to the cause(s)			
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	Y ( )			29c. Licens		29	d. Date signed (M				
	3	10	<b>P</b>	my			D33	280		March 15	, 2007			
17,122.0	THE		30. Name and address of person Sunil K.	Gupta, M.I	0., 625	Kent	Print) Avenue,	Cumberla	nd, MD 2	21502	W			
		State State MAR 1 5 2007 32. Registrar's Signature												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | | | | Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** Dillard Williams 16,3007 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Prince George's Lanham Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year, **Funeral** Days Months Hours 1 X M 2 □ F Yrs. 577-38-9672 90 May 10, 1916 Georgia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Maryland Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number a or 9304 Woodberry Street 20706 TISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. the Medical Examiner 1 Yes 2 No WIII If Yes, Give Year or Dates: 1 Never Married 2 Married 'or 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th marked other than College (1-4or 5+) Maintenance Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jack Andrew Williams Lynn Dillard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and z tment of Health ? Frances Williams (Wife) 9304 Woodberry Street, Lanham MD 20706 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 3/21/2007 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature | Funeral Service Licensee 9013 Annapolis Road, Lanham MD 20706 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia neeks **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Dicease of it just) that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending Plant hours after death.

Funeral Director: After the state of the state o After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 9 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20704

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** William Wean+ 6:15 PM March 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Medical Center of Maryland nivers ity If Under 1 Year 8. Date of Birth (Month, Day, Aug. 8) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 218-24-8994 1**∑**M 2□F **1928** 78 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 Yes No Director Frederick Maryland Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 60 East Moser Road 21788 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: **Korean** 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta item 27 Is marked Scott Weant Clara McGlaughlin ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Weant/Wife 60 E. Moser Road, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 3/21/2007 Thurmont, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 104 E. Main Street Thurmont, Md 21788 23a. P.rrt. Intel the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, in least failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 days /Medical Due to (or as a consequence of): Examiner Blast Crisis eukemia unknown Sequentially list conditions, if any, leading to infine lists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-tran Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Tes funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To After this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street Baltimore. Gandh +mish gistrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 9 Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

			1- State of Maryland Department State of Maryland Certification	ent of Health and Nate of Death		eg. No 2007	10276
	Physici	<b>an</b>	1. Decedent's Name (First, Middle, Last)		2. Date of Deal Month	th Day Year	3. Time of Death
	'/Medic	al	William M. Westerfield	ity, Town, or Location of Death	March	15 2007 4c. County of Deat	10:50 A M
	Examin	er	500 Schley Avenue	Frederick		Freder	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	der 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		216-74-3830   128 M 2   F   47   Yrs.   Mont	ns Days Hours Min.	(Month, Day Aug. 12	, 1959 Ma	aryland
	and ww		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	-			10d. Inside City Limits
	Maryl -f sho iied a	ţ	Maryland Frederick Frederick	ζ			1⊠Yes 2□No
	h the or 28a or 28a	Director	10e. Street and Number 10f.	Zip Code	1	0g. Citizen of What Co	untry?
	th wit 23a c 1st be	alD	500 Schley Avenue	21702		United S	tates
920	be filed within 72 hours after death with the Maryland Hygiene.  4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	3 ☐ Widowed 4 ☑ Divorced   If Yes, Give Year or Dates:	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto s 2凶No Specify:	pecify Yes or No- Pican, etc.)		
21215-0036	- 3 60	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	work done during most of work	king	16b. Kind of Business/	
	filed withir Hygiene. other than	5	10 Roo		4000 - 44114	Construc	tion
gue	should be filed within of Mental Hygiene. marked other than matic event, the Manatic event	Be	17. Father's Name (First, Middle, Last)		,	Maiden Surname)	
Maryland	s 1 and 2 should t f Health and Ment item 27 is marked other traumatice	ဥ	Edward F. Westerfield, Sr.  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Addr	ess (Street and Number or Ru	A. Johns ral Route Numbel		Zip Code)
Z	od 2 lith a 27 is rtra		David W. Westerfield / Brother   32565 D	iscovery Drive	Easton	n, Maryland	21601
ore,	ges 1 ar t of Hea lfitem or other		20a. Method of Disposition  1 ☐ Burial 2 XICremation 3 ☐ Removal from State	Name of Marc	Date h 19,	20c. Location - City or	Town, State
Ĕ	Z # en Z		4 □ Donation 5 □ Other (Specify) Stauffer Cre	matory	2007	Frederick,	
Baltimore,	permit. Pag Departmen Important: any Injury once.		1621	Opossumtown Pi	ke Fred		
2		, ,	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the r shock, or heart failure. List only one cause on each line.	node of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Janue			
	Examiner	L	Due to (or as consequence of):	i.			43
	nsit	Examiner	Sequentially list conditions, and the sequence of the cause. Enter Underlying Cause (Disease or injury			- 7	UZ
Ć	execunation and sale tra	Exal	resulting in death) Last  C.  Due to (or as a consequence of):	- 1			16
68760,	ficate be executed physician and is the burial-transit	edical	a Hype Iwphre	Cardnon	140P	orthy	Yes
.O. Box	ath certi attending for use a	Physician/M		c pregnancy (specify)		23d. Date of del Month	ivery Day Year
ds, P.	uires that the de n signed by the a ld be detached i	þ	Part II. Other Significant conditions commoding to death but not resulting in the discension	ng cause given in Part I.	23e. Did to	bacco use contribute to es 2 No 3 DP	the cause of death?
Records,	The law requir cate has been si page 2 should	Completed			24a. Was a autop: perfor	sy prior to death?	utopsy findings available completion of cause of
		Be Co		26. Place of Dea	1 Yes th (Check only or	2.124√No 1 □ Yes ne)	2□ No
Ž	S S	To B		DOA Other: 4 Nursing H	ome 5 Resid	ence 6 □Other (Spe	cify)
	<u>a</u> + <u>e</u>			28c. Injury at Work?	28d. Describe h	ow injury occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director After completely filled in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be determined 4 ☐ Homicide determined building, etc. (Specify)  28e. Place of injury - At home, farm, street, fact building, etc. (Specify)	1 ☐ Yes 2 ☐ No	28f. Location (S City or Tow	itreet and Number or Ri n, State)	ural Route Number,
	ital o					()	
	e Host 24 hor Fune etely fi	Medical	29a. Certifier (Check only one)  2□ Medical Examiner: On the basis of examination and/or investigation and one)  2□ Medical Examiner: On the basis of examination and/or investigation and manner stated.				
	To the vithin To the complex	Me	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mont	h, Day, Year)
			> Sesse Tall mo	000540	140	3/15	102
(	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	shman's 1			
				ghman's 1	rome, f	redis de	MO2170E
	Sta Regist		MAD 1 0 2007 Marie H And				

State Registrar

Division or Vital Records, P.O. Box 68760.

Jewell

32. Registrar's Signature **R 2 0 20**07

to completed cause of death (Item 23a) (Type, Print)

30 Name and address of person 012 CR ate filed (Month, Day,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 16, 2007 Phillip Walls 7:27 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1**X** M 2 □ F 69 Days Hours 383-32-2844 4-20-1937 MICHIGAN Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Y☐Yes 2☐No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 88 Chatham Court 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bolis Walls Ruth Dudenas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christel M. Walls (wife) <u>88 Chatham Court, Berlin, Md. 21811</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4 Donation 5 Dother (Specify) 3-20-2007 Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Aves Due to (or as a consequence of): Congestive Heart Failure 2 mouths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 CR/Outpatient 3 DOA

**Examiner** the death certificate be executed and attending physician for use as the buria as detached ģ signed d be det

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending Physician:

Examine Physician/Medical Completed by Be မ Medical Certification:

**Physician** 

/Medical

Examiner

10a, State

**Funeral** 

Director

a or 28a-f show t be notified at

be filed within 72 hours after death wi ntal Hygiene. ed other than "natural", or items 23a ( event, the Medical Examiner must b

h and Mental Hygie 7 Is marked other t

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev

Physician /Medical

ould be t

Baltimore, Maryland 21215-0036

Director

Funeral

ð

Completed

Be

has certificate within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

29a. Certifier

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be 4 ☐ Homicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29b. Signature and fittle of certifier ~ mD

29c. License number D58755

29d. Date signed (Month, Day, Year) MARCH 17, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLENN ARZADON 9714 HEALTHWAY DRIVE BERUN, MD Z1811

Registrar

31. Date filed (Month, Day, Year)

MAR 1 9 2007

32. Pøgistrar's Signature

BA10+1

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Luther Andrew Welch 13, March 2007 7:30 р м 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **X**□M 2□F Months Days Hours Yrs 215-36-3895 68 July 4,1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits Maryland Charles 1 ☐ Yes 2 No Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2924 Edgewood Road 20616 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Machinist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Dyson Welch Evelyn Mildred Peterson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece Deborah Hall Bowie 2924 Edgewood Rd., Bryans Road, Md. 20616 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Trinity Memorial Gardens 2007 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20640 Approximate Interval Between Onset and Death Immediate Cause (Final 57 5 disease or condition resulting in death) Due lo (or a la o equence of): nemman Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): molce Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown

Physician /Medical **Examiner** 

permit. Pages 1 and 2 Department of Health Important: #f Item 27 any injury or other tra once.

Physician

/Medical

10a. State

Directo

Funeral

Completed by

Be ပ

Examiner

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death with the Maryland

72 hours after

1 and 2 should be filed within 'Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

O. Box 68760

Records,

Division or Vital

4161

burial-tran as the b

Examiner Physician/Medical Completed by Be 10 Certification:

Medical

law requires that the death certificate be executed attending physician signed by cate has been si page 2 should l The certificate Hospital or Attending Physician: After this thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu

Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlying	ng cause	e given in	Part I.			bacco us	se contribute to the cause of d No 3 Probably 4 □L	eath? Inknown				
							24a. Was a autops perfor 1∐ Yes	sy	24b. Were autopsy findings a prior to completion of cadeath? 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical examiner?	5. Was case referred to medical							26. Place of Death (Check only one)						
1 Yes 2 No	Hospital: Inpatient 2	]ER/Outpatient 3□	ne 5 Residence 6 Other (Specify)											
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M		Injury at Work? 1 ∐ Yes	2 □ No	28d	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac fy)	tory, off	fice		28f.	Location (Si City or Town	treet and n, State)	Number or Rural Route Number	ber,				
29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at th	ne time, d	ate and plac	e, and urred	d due to the c at the time, d	ause(s) a	and manner as stated. place, and due to the cause(s)					
29b. Signature and title of certifier			29c. Lic	ense nur	nber		2	9d Date	signed (Month Day Year)					

D005321

29d. Date signed (Month, Day, Year)

B 55 State Registrar

within 2.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zafar Ansari, D.D., Cenna Center, 7-E Post Office Rd., Waldorf, Md. 20602-2744 31. Date filed (Month, Day, Year) 32. B

MAR 1 9

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John Paul Zombro March 14 2007 13:55PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1028 Potomac Avenue Washington County Hagerstown 7. Age (In yrs Jast birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yei March 12 Birthplace (State or Foreign Country) **Funeral** Days Year) Months Hours **Director** Maryland -1949212-50-9032 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be multiled at 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1028 Potomac Avenue 21742 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or items 23a enty injury or other traumatic event, the Medical Examiner must page. 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 ☑ Yes 2 ☐ No 9 – 11 – 67 If Yes, Give Year or Dates: 9 – 10 – 71 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Liquor Store Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DonaldE. Zombro, Sr. Mary C. Noland Zombro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marye R. Zombro (wife) 1028 Potomac Avenue Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 3-20-2007 Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagersotwn Maryland 21742 unto My 23a. Part1. Enter list disease, or complications that as sed the death, shock, or he in failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cars disease or condition resulting in death) /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **X** No Completed 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? certificete or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 3 DOA After th 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) .u þ 4 Homicide within 24 hours e To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title 29d. Date signed (Month, Day, Year) 2007 ompleted cause of death (Item 23a) (Type, Print) Ave Suite 101 3H-10-1 Pennsylvania 31. Date filed (Month, Day, Year) State MAR 20 2007 Registrar

	1- For Amend #24a,25,26,27,29a, perful, 8856,47707 II Certificate of Death	d Mental Hygien	2007 10281
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Automatte Anetdom 150	2. Date of Death Month Da	ay Year 3. Time of Death
Examiner		eath 40	c. County of Death
	Oakcrest Village Parkville	les la Birth	Baltimore
Funeral Director	5. Social Security Number  219-28-6426  6. Sex  1 M 2 X F  93  Yrs.  1 If Under 1 Year   If Under 1 Year   If Under 24 H   Months   Days   Hours   M	in. (Month, Day, Year	9. Birthplace (State or Foreign Country) 1913 New York
pu	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		
Maryla Fishov fied at	MD D d d		10d. Inside City Limits 1 ☐ Yes 2√☐ No
iter death with the Mar ritems 23a or 28a-f st liner must be notified Funeral Director	10e. Street and Number 10f. Zip Code	10g. C	itizen of What Country?
is 23a	8832 Walther Blvd 21234  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Casaita Vanan Na	USA  14. Race - American Indian,
J36	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates: 42–46   1 ☐ Yes 2X No Specify:	erto Rican, etc.)	Black, White, etc.  Specify: White
29 C. 121215-0036 ed within 72 hours at lygiens than "natural"; or the Medical Examilation or the Medi	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of volume (Inc. DO NOT use retired)	vorking 16b. F	Kind of Business/Industry
212 212 ed with ygiene. t, the h	Elementary/Secondary (0-12) College (1-4or 5+) Tegistered nurs	se 1	nealthcare
Maryland Maryland d 2 should be fit if and Mental by It is and wental by traumatic event	17. Father's Name (First, Middle, Last)  18. Mother's N	lame (First, Middle, Maide.  Dewey	n Surname)
aryla should Ind Men Ind Men Ind Men Ind Men Ind Men Ind Men Ind Men Ind Men Ind Ind Ind Ind Ind Ind Ind Ind Ind In	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or	,	or Town, State, Zip Code)
e, Mi	Oakcrest Village 8834 Walther Blvd	Parkville, N	MD 21234
Baltimore	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	Date 20c. L	ocation - City or Town, State
Ball permit Depart Import	21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Boa: Baltimore, MD 212	rd 655 W. Bai	ltimore Street
उँ विकास	23a. A rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card sh k, or heart failure. List only one cause on each line.	liac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Nuse (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):		Offset and Death
Examiner	Sequentially list conditions		
total	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
And have been been been been been been been be			
68760 efficate be entitle to the buriants th	d		
ox 6 certific nding p	IF FEMALE: 23b. Was decodart system. 23c. If yes, outcome pf pregnancy		22d Date of delivery
P.O. Box nat the death certified by the attending letached for use a Physician/M	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of delivery  Month Day Year
P.O P.O nat the d by th etache	9 Unknown	00 000	
I ( . 30 pm I Records, P.O. Box ( The law requires that the death certif the has been signed by the attending bage 2 should be detached for use a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Cor w req s beer shou	CHF	24a. Was an	24b. Were autopsy findings available
	<u> </u>	- autopsy performed? 1∐ Yes 2\0\00000\00000\00000\00000	prior to completion of cause of death?
r Vital Re yystcian: The director, page	examiner:	eath (Check only one)	
O	1 Inpatient 2 EH/Outpatient 3 DOA 4AANursing	Home 5 Residence	
Vision or Vita Attending Physician: redeath.  The first this certification to the function of the first this certification.  The first this certification of the function of the function of the function of the function of the first this certification.	27. Manner of Death 28a. Date of Injury 28b. Time of Sec. Injury at Work? 2 ☐ Accident Investigation 28b. Time of Injury 38b. Time of Injury 48b. Time of Injury 4b. Time of	28d. Describe how inju	iry occurred
S/3>/ Division of Division of that or Attending P rs after death ral Director: After led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
Division of Division of To the Hospital or Attending Phenthin 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification: T	29a. Certifier  (Check only one)  1	ace, and due to the cause(s ccurred at the time, date ar	s) and manner as stated. Indiplace, and due to the cause(s)
To th within To th comp	29b. Signature and title of partifier  29c. Signature and title of partifier  29c. Signature and title of partifier	29d. Da	ate signed (Month, Day, Year)
	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	D 1,	110,111,124
State	31. Date filed (Month, Day, Year)  32. Registrar's Signature	) Januar	cill vola 420
Registrar	APR 0 2 2007 Beau St freele		
DHMH 17 Rev 1/2001			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2007 05.55 AM corge 0 28 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE INIVERSITY SPECIALTY HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 20 1955 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. 218-60-3845 51 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 Hollins Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Completed by American 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction aborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Roose Margarett ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21223 SX. Dans Boose/WIFE Guendelyn Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bay View Crematory Baltimore, my 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Hani 15126 Beld acilly Exmercal Service, P. A. 21. Signature of Funeral Jervico Licens Bastimone mo 21206 Belain 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner QUAMOUS CELL CARCINSMA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit ENCEPHANDPATTY ANOXIC Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 TREATENTION Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò ( FIZURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISMUDER Completed newing 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No DIAGETED this certificate 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

AMO 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

TANOMA

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 egistrar's Signature

300 traismy place

State Registrar

29c. License number

D50,76948

SUTE 3H BATEMENTE

2007

**Physician** /Medical

Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

**Funeral** Director

For State Registrar	State of Ivia	ırylanu / L	Department of Certificate of			iene	107	10283
Decedent's Name (First, Middle, Last,	()		Ooi unou.	Dou	2. Date of Death	1	d No.	3. Time of Death
IDA LORRAIN		IN			March	29 <sup>Day</sup>	2007	4:20 PM
. Facility Name (If not institution, give Singi Hospital o	of Baltim	1000	4b. City, Town, Baltin	n, or Location of Death		4c. Cou	inty of Death	
Social Security Number 6. Sec	7. Age	(In yrs. last bin	nthday) If Under 1 Yea	ar If Under 24 Hrs.	8. Date of Birth	- 1	9. Birthi	place (State or Foreign
214-22-2325	□ M 2 X F 78	8	Yrs. Months Days	rs Hours Min.	(Month, Day, 2-22-29	Year)	COL	mtry) MD
a. State 10b. County		10c. City, Town	n or Location					10d. Inside City Limits
MD		BALT	TIMORE					1X Yes 2 □ No
e. Street and Number			10f. Zip Code	216	10	-	of What Cou	ntry?
4157 FAIRVIEW  Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of	f Hispanic Origin? (Sp	necify Yes or No-	14. F	Race - Americ	
1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give		If Yes, specify Cu	uban, Mexican, Puerto	Rican, etc.)	E	Black, White,	etc.
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V. Father's Name (First, Middle, Last) WILLIS BELL				18. Mother's Nam	e (First, Middle, Mi			
9a. Informant's Name/Relationship (Type	ype, Print)	19b	. Mailing Address (Stree					
FELICIA DUKES /DA	AUGHTER		2322 OCA	LA AVENUE,	, 2ND FLR	., BA	LTO.,	MD 21215
a. Method of Disposition 1  Burial 2 □ Cremation 3 □ R	Removal from State	20b. Place of cemeter	f Disposition (Name of ry, crematory or other pla	Inna	Date 26	Oc. Locatio	on - City or To	own, State
				N4/04	'/07 L	AUREL	MI)	
4 □ Donation 5 □ Other (Specify)	)		CIONAL MEM ]	PK  04/04				
4 □ Donation 5 □ Other (Specify)	)		22. Name and Addr	PK 04/04  Iress of Facility JA	AMES A. M	ORTON	& SON	NS GF.H., I
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within 24 hours after death.

To the Funeral Diractor: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar 30. Name and address of person who completed cau
Eileen S. Zingman, DO
31. Date filed (Month, Day, Year)
32. APR 0 2 2007



and address of person who completed cause of death (Item 23a) (Type, Print) KES-000

DO Sinai Hospital of Baltimore
32. pogistrar's Signature

			<b>1-</b> For State of Maryland / Dep Registrar		lental Hygi	iene	
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death		g. No.)	10281
9	Physici	an	Edward L. Biller		2. Date of Death Month	2 <sup>Day</sup> , 200 <sup>Year</sup>	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March	4c. County of Dea	
)	⊏xamır	er		Parkville		Baltimo	
	Funeral		8820 Walther Blvd., Apt. 1114  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	0.00	thplace (State or Foreign
	Director		216-20-8415 15 N 2□ F 81 Yrs.	Months Days Hours Min.	9-24-19	9 2 5	ountry) W V
	pu ,		Usual Residence of Decedent				
	aryla show d at	ř	MD Baltimore 10c. City, Town or L				10d. Inside City Limits
	he M 28a-f otifie	Director	Talkvi				1 ☐ Yes 21X No
	with t		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
	eath Is 23 must	Funeral	8820 Walther Blvd., Apt.1114  11. Marital Status   12. Was Decedent Ever in U.S.   13.	21234		USA	201110
	ter d item iner	En	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
36	urs a	by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 □ No If Yes, Give ☐ WIII	1 ☐ Yes 2 X No Specify:		Specify: W1	nite
Ö	2 hor	Completed by	15. Decedent's Education 16a. Dece	dent's Usual Occupation	§ 1	6b. Kind of Business	
21	thin 7 e. an "r Med	ple	Liettleritary/Secondary (0-12)   College (1-40r5+)	e kind of work done during most of worki DO NOT use retired)	ng		- 1
2	ed wi	Con	6 Educ	ational Adminis	trator	Educati	Lon
p	be fill tal H d oth even	Be	17. Father's Name (First, Middle, Last) Edward L. Biller, Sr.	18. Mother's Name		laiden Surname)	
<u>\</u>	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ဠ		Eva Jon			
<u>a</u>	ar is		19a. Informant's Name/Relationship (Type. Print)  Lee M. Biller - Wife 8820	ng Address (Street and Number or Rura	ıl Route Number,	City or Town, State,	<sup>Zip Code)</sup> 21234
ص رف	Heal Heal em 2			Walther Blvd.,	Apt. 111	4. Parky Oc. Location - City or	ville, MD
Baltimore, Maryland 21215-0036			I Dunai 2 Dolemation 3 Dremoval nom State	matory or other place)			
₫	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Bayvie  21. Signature of Liberate Service Licenses 2	Crematory3-29- 2. Name and Address of Facility Brace	-07	Baltimor	e, MD
ñ	Dep Imp any		) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Brac	dley-As	hton Fun	eral Home,
	A 1 (115)		23a. Part1, Enter the disease, or complications that caused the death. Do not en	134 Willow Sprinter the mode of dying, such as cardiac o	r respiratory arres	21222 st,	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	glioma			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a.  Due to (or as a consequence of):	THOTOLA			
	Examiner		Sequentially list conditions				
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  b. Due to (or as a consequence of):				
	ecute and -trans	Examin					
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ğ	ficate be executed physician and s the burial-transit	ᇹᅵ	d				1901
ZOX C	certif Iding Ise as	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy				
ň	death certifi e attending d for use as	ciar	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of del Month	Day Year
j.	t the cachec	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 L 9 Unknown 9 Unknown				
ı,	s that med t	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
coras	requires that een signed b rould be deta	pa			1 ☐ Yes	2	obably 4 Jonknown
Ť)	law re as bee 2 sho	Completed			24a. Was an	24b. Were au	itopsy findings available
Ē	The late hapage	ĕ			autopsy performe 1 Yes 2	prior to death?  No 1 □ Yes	completion of cause of
N   [2]	stan: ertifica ctor,	Be	25. Was case referred to medical examiner?	26. Place of Ceath			2 No
5	hysic this or	2	1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Hom	ne 5 Residen	ce 6 ∐Other (Spec	cify)
	ing P	ü	27. Manne of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) Injury	Work?	8d. Describe how	injury occurred	
200	ttend leath. tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of Johnson form etc.	M 1 ☐ Yes 2 ☐ No			
2	or A after of Direction by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, str	eet, factory, office 2	8f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
_	spital ours neral filled		29a. Certifier Certifying Physician: To the best of my knowledge, deat	OCCUrred at the time, date and place a	and due to the cou	100(0) and many	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	e and place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d	d. Date signed (Montl	n, Day, Year)
	11		· manuful	1) 24242	_	3/28/0:	7
5	1/		30 Name and address of person who completed cause of death (Item 23a) (Type,	Print) 0 T7 /	1 12 1	1.1.1.	Mdzizzy
U	1		1) Mich Bunchthon Mi) 8	800 wellerly	(V)	ankville	100000
	Stat Registra		31. Date filed (Month, Day, Year)  APR 0 2 2007  32. Tegistrar's Signature	all s			
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# Fatient turn AP: Heurietta Blumberg Baltimore, Maryland 21215-0036

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ds, P.O. Box 68760,	
Vital Records	
ivision or Vi	
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HENRIETTA   BLUMBERG   Month   Day Wear   Month	de City Limits  Yes 2 No
HENRIETTA   BLUMBERG   Month   Day My Year   Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day My Month   Day Month   Day My Month   Day	tate or Foreign  de City Limits  Yes 2   No
Funeral Director    Part	de City Limits  Yes 2 No
217-12-5414	de City Limits  Yes 2 No
10c. City, Town or Location   10c.	NESS
Elementary/Secondary (0-12) College (1-4or 5+)    College (1-4or 5+)   OWNER     College (1-4or 5+)     Coll	X E NESS
Elementary/Secondary (0-12) College (1-4or 5+)    College (1-4or 5+)   OWNER     College (1-4or 5+)     Coll	NESS
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Elementary/Secondary (0-12) College (1-4or 5+)    College (1-4or 5+)   OWNER     College (1-4or 5+)     Coll	
Physician //Medical Examiner  23a. Part1. Enterthe disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximately a completation that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
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Se uentially list conditions f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influted events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	aus
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d.    F FEMALE: 23d. Date of delivery   1   1   1   2   1   1   2   3   3     2   3   3     2   3   3	- ti
of the past 12 months?    Solution   Soluti	Year
23e. Did tobacco use contribute to the cause	
Type 2 L Mo 3 Probably 4  Type 2 L Mo 3 Prob	
24a. Was an autopsy finding prior to completion death?    Chronic una Disense   24b. Were autopsy finding prior to completion death?   1   Yes 2   1	of cause of
September   Sept	
27. Manner of Death   28a. Date of Injury   28b. Time of Injury	
27. Manner & Death 1 Natural 5   Pending investigation 3   Suicide 4   Homicide 5   Pending investigation 3   Suicide 4   Homicide 5   Pending investigation 4   Homicide 5   Pending investigation 5   Pending investigation 6   Could not be determined building, etc. (Specify)  28b. Time of Injury at Work? M 1   Yes 2   No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred	Number
building, etc. (Specify)	
The state of the s	ise(s)
	ar)
30. Name and address of person who complete cause of death (Item 23a) (Type, Print)  Christopher Faustin, MD 8 inai Hospital of Baltimore	′
Christopher Faustin, MD sinai Hospital of Baltimore	′
Christopher Faustin, MD 8 inai Hospital of Baltimore  State Registrar  APR 0 2 2007  Registrar's Signature  APR 0 2 2007	′

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #1,4a, perMD, 10e,15,18a9b, perFH, 1966, 4 16407 TT Registrar 1. Decedent's Name (First, Middle, Last) Jacqueline Mary Chenowith 2. Date of Death 3. Time of Death **Physician** Month Day Jacquelin Mary Chenowi th March 29 2007 07:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greter Baltimore Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year)
May 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. **Funeral** 1 □ M 2 🕇 F Days Months Hours 217-46-2365 63 Director 1943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at MD Baltimore Baldwin Director 1 ☐ Yes 2 X No 10e. Street and Number 14214 Green Road 10f. Zip Code 10g. Citizen of What Country? 1424 Green Rd. Items 23a 21013 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 Married "natural", or White 1 ☐ Yes 2 🔀 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F John Bobb Catherine ပ **Taornina** traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important; if item 27 is any Injury or other traugnce. Mr. Mahlon Chenowith / Husband 1424 Green Rd. Baldwin, MD 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Garden's 4/02/2007 4 □ Donation 5 □ Other (Specify) Timonium, MD 21. Signature of Funeral Service Licensee Kimberty Davidson 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Luncinoma **Physician** ulia one-year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examin The law requires that the death certificate be executed physician and s the bunal-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an ate has b autopsy performe 1∐ Yes 2√No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death
1 X Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury nours after death.

neral Director: At filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) orth Charles St. Towson, MD 21204 65 Nunghall 69

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Egistrar's Signature

Jennis John Clark	1 F	- For State Registrar	State of Mary	land / l	-	ent of He ate of De		d Mental		Re	g. No.	200	1 0 1.20
Physician Medical Examine	•	1. Decedent's Name (First, Dennis J.							l N	Date of Death Month Iarch 26,	Day	Year	3. Time of Death 1710 hrs
Pale day		4a. Facility Name (if not ins		number)		4b. Cit	y, Town, or	Location of D		iaicii 20,		ounty of Death	
		6808 Fifth Avenue					ndalk	- <del></del>				timore Cou	•
Funeral Director		5. Social Security Number			n yrs. last birtl 49		nder 1 Year		4Hrs. 8. Min.	Date of Birt		Foreig	thplace (State or in NJ untry)
any	-	Usual Residence of Deced 10a. State 10b. Co		10	c. City, Town	or Location							10d. Inside City Limits
<u> </u>		MD Ba	altimore		Dunda	1 k							1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	ן פניני	10e. Street and Number 6808 Fifth	h Avenue				Zip Code 1222		_	10	g. Citizen USA	of What Coul	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Filmeral Director									. Race - Ameri White, etc.	can Indian, Black,			
safter d		3 Wildowed 4 Divorced in res, give rear or Dates:								ecify: Whi			
hours 'natur	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of during most of working life. DO NOT use retired)												
5-0036 Hygiene other than "natural the Medical Examin		1 2 CSX :							Rail	road			
Baltimore, MD 21215-0036 ocmit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene important: If item 27 is marked other than injury or other traumatic event, the Medica		17. Father's Name (First, M			·			18.Mother's N Helei					-
212 nould be id Menti is mark fic ever		19a. Informant's Name/Rel	ationship (Type, Print )			. Mailing Addr		t and Number	or Rural	Route Num	ber, City o	or Town, State	
ore, MD 2121 St 1 and 2 should be fi St 1 and 2 should be fi St 1 and 2 should be fi St 1 and 2 should be fi St 1 and 2 should be fi To Be	L	Melissa C.	lark - Da	ughte		808 Fi			e, [			MD 21 ation - City or	
nore, ages la nut of He nt: If ite other t		1 Burial 2 K Crer	mation 3 Removal	from State	cremato	ory or other pla ew Cr	ce)					timor	
Baltim permit. Pa Departmer Importan injnry or	1	4 Donation 5 Oth 21. Signature of Funeral Sc	ervice Licensee		·	22. Name a	nd Address	of Facility R	rad1	6 V - A	shto	n Fun	eral Home
m 월호트로 Physician	1	23a. Part I. Enter the disea	ase or complications that	caused the	death Do no	t enter the mod	134 <sub>W</sub>	111ow	Spr ac or res	ing piratory arre	Road	2.1.2 or heart	2 2 Approximate Interval
/Medical		failure. List only one of the limmediate Cause (Final diagram)	cause on each line.				, 3.						Between Onset and Death
Examiner		or condition resulting in de		a consequ	ence of):								
iner		Sequentially list conditions if any, leading to immediate cause. Enter Underlying C	e Due to (or as Cause	a consequ	ence of):								
nted d ansit Fxaminer	Lya	(Disease or injury that initial events resulting in death)	SHRC	a consequ	ence of):							-	
oe execucian an urial - tr		UNPENDED	AMENDE	)									
3760, ficate be g physici s the buri	2	IF FEMALE: 3b. Was decedent pregnar	at in the	s, outcome	of pregnancy	Fetal dea	oth 3	Ectopic pro	ennancy			ate of delivery	) Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit pedical Certification: To Be Commleted by Physician/Medical Expedical Certification:	ysicia	past 12 months?  1 Yes 2 No 9	4 Pre	gnant at tim known	ne of death 5								,
P.O. B s that the d gned by the detached by Phy		Part II. Other significant o	conditions contributing	to death be	ut not resulting	in the underly	ring cause g	iven in Part I.			2 V N	_	the cause of death?
duires I	ומ		<del></del>		<del> </del>	· <del>- ·</del>			-	24a. Was a			topsy findings available
Vital Records, lysician: The law requires his certificate has been significate, page 2 should be director, page 2 should be Commilered.									-	autops perforr	ned?	death?	ompletion of cause of
tal Rection: The certificate ector, page		25. Was case referred to m	nedical				26.Place	of Death (Ch	eck only		₽ No	1 Ye	es 2 No
Vital  ysician  ysician  directo		examiner?	Hospital:	Inpatient	2 ER/OL	utpatient 3	DOA	Other N	ursing Ho	ome 5 F	Residence	e 6 🗸 Other	Scene
Division of Vital Records, P.O. rat of Attending Physician: The law requires that the ra after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach or rifteration: To Be Completed by P.		27. Manner of Death  1 Natural 5	28a. Da Pending FOUN	te of Injury nth, Day,Year ID:	FOU		1	ryat Work? ′es 2 ✔ No	- ISut	Describe h pject hang			
Division pital or Attent ours after death teral Director: filled in by the	<u> </u>	2 Accident	Investigation Mar 2	6, 2007 ace of Injury	y - At home, fa	) hrs irm, street, fact						Number or Ru	ral Route Number, City
Div	Subject hanged himself    Subject hanged himself   Subject hanged himself												
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bedieval	Zear. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										e cause(s)		
F × F o	Ĕ	4	9b. Signature and title of certifier 29c. License number 29d. Date signed March 27, 20									nth, Day, Year)	
7	-	30. Name and address of p		ause of dea	th (Item 23a)		0.0.1	vi. L.			IVIGITOR	27, 2007	
2			ssistant Medical Ex			Street, Ba	ltimore,	MD 21201					
Stat Registra	v	31. Date filed (Month, Day,	Year) 32	egistrar's	Signature	book							-
	_	LI F. C.	the court of the c	10,200		-							

			For State Registrar	State of Ma	arylan		artmen			nd Me	-	giene Reg. No			1.00	0.0
ľ	Physici		Decedent's Name (First, Middle, Last)     Anto	nio So	Cua						2. Date of De Month		7. 11.	ear	3. Time of D	
	/Medic Examin		4a. Facility Name (If not institution, give s Suburban Hospital		000		4b. City,		Location of thesda	Death	iarcii	4c.	County of	Death		
^	Funeral Director		362-30-7366	M 2□F	e (In yrs. I 74	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min	B. Date of Bir (Month, Date uly 23	v. Year)	1	Coun	lace (State or try) ppines	
	Maryland -f show fied at	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgomen	cy	10c. City	, Town or Lo								1	0d. Inside City	
	with the 3a or 28a st be noti	Il Director	10e. Street and Number 7525 Cayuga Avenue				10f. Zip		0817				izen of Wha		•	
920	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Funeral		2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Deced If Yes, spec	dent of Hi cify Cuba		in? (Spec Puerto R	ify Yes or No ican, etc.)		14. Race - Black, Specify:	Americ White,	an Indian, etc.	
Maryland 21215-0036	d within 72 ho giene. ir than "natur the Medical i	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		5+)	(Give life.	dent's Usua kind of wo DO NOT us	rk done d se retired	ation during most o	of working	rking 16b. Kind of Busin				dustry	
yland 2	ould be filed Mental Hyg larked other	To Be C	17. Father's Name (First, Middle, Last)  Cua Oh		•				Ch	io	First, Middle So					
e, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any futury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type Shoke-Hwee Cua /	,	Jook D	7525	Cayug	a Av	enue,	Betl	nesda,	Mar	y1and	20	817	
Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		1	lace of Dispo emetery, cre-	Cremat	orium	Inc.			Beth	nesda,	sda, Maryland		
Bal	permi Depa Impo any Ir		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Be 7557 Wisconsin Avenue, Bethesda, Ma									Mary1	Maryland 20814-3501			
ز	Physician /Medical Examiner		23a. Part1. Fater the disease, or compli- shock of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Respirat  Due to (or as	ne. Cory a consequ	Failur uence of):	e e								Interval Betwo	een eath
8760,	ate be executed hysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	Right Pneumonectomy and Partial Left Pneumonectomy  Due to (or as a consequence of):  Two Primary Cancers of Lung  Due to (or as a consequence of):						comy	14 Years		5		
O. Box 6	eath certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp		'				23d. Date o Month		•	ear
rds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions con Pneumonia	tributing to death b	ut not resu	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did t			ıte to th ☑ Prob	ne cause of de ably 4 □Ur	eath? nknown
or Vital Records	2 38 2	Completed									24a. Was auto perfo 1∐ Yes	psy ormed?	pric	r to cou th?	psy findings av npletion of cau 2 □ No	vailable use of
r Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital:	ent 2 🗍 I	ER/Outpatier	nt 3 DC	Othe	Dr.	,	<i>Check only o</i> e 5□ Resi		6 □Other	(Specif	γ)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: T	27. Manner of Death  1   ↑ Natural 5 Pending  2  ↑ Accident investigation	28a. Date of Inju (Month, Da		28b. Time o Injury	f 2	28c. Injun Worl 1 ☐	yat k? Yes 2 ☐ No		3d. Describe	how injui	ry occurred			
Division	tal or Attures after de al Directure ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At ho c. <i>(Specif</i> y	me, farm, str	eet, factory	, office		28	f. Location ( City or To	Street an wn, State	nd Number e)	or Rura	l Route Numb	e <i>r</i> ,
	To the Hospital of within 24 hours af To the Funeral Completely filled in	Medical	29a. Certifier 1 M Certifying Phys (Check only one) 2 Medical Examir		f examinat											
<b>)</b>	Vithir Vithir Comp	Me	29b. Signature and title of certifier	relater	/		290	DO	number 35 f	9			te signed <i>(l</i> March		Day, Year) 2007	_
	15		30. Name and address of person tho co	mpleted cause of c	6000	Execu	ıtive	B1vc	1.#300	, Ro	ckvill					
	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 2 2007	32. Registr	ar's Signa	ture	No.									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #6, perFH, G866, 4/11/07 TT Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** DANGHE 100 11.50 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4:Ma28 ohn Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Min 10 Days Hours Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director altimore arbville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Mead items 23a 30 Maidbrook by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black

16b. Kind of Business/Industry 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. College (1-4or 5+) administrater ocial S 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Dice eanette ames enhons and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If Item 27 Is any Injury or other trau 1900 Maid brook Ad Parkville mo Matthew A Husband 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1 Valley Cennity OH Olo 2007 Timonium, MD 22. Name and Address of acility Vaughn C. Green funciu Senne 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 8728 Liberty Boad, Mandallotan mo 21133 23a. Part1. Enter t. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IPERKALEMIA hours /Medical Due to (or as a consequence of) Examiner ACIDOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit NUJER VO EMIA

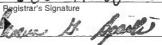
The to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ Mo should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Aden DraccinomA 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 3/28/ PES-.000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. BAHIMORE MALYland 21287

State Registrar

31. Date filed (Month, Day, Year)



170/FE

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:15 PM March 250ay 2007 ear **Physician** William Nash Drohan /Medical 4a. Fecility Name (If not institution, give street and number)
21505 Sun Garden Ct. 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Examiner Germantown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. 08/72/24/1946 Birthplace (State or Foreign
 Maountry) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral 12** M 2 □ F 557-64-2637 Yrs Director Usual Residence of Decedent a filed within 72 hours after death with the Maryland It Hygiene.
other then "netural", or Itams 23e or 28a-1 show 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at MD Germantown 1 ☐ Yes 2/2 No Montgomery Director 10g. Citizen of What Country?
United States 10e, Street and Number 10f. Zip Code 20876-21505 Sun Garden Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industrylogy (Specify only highest grade completed) College (1-4055+) Elementary/Secondary (0-12) Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame)
Christine Nash . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Itam 27 is marked off jury or other traumatic even Be Drohan Sr. Robert 19a. Informant's Name/Relationship (Type, Print)
Marian Drohan/Wife 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 21505 Sun Garden Ct. Germantown, MD 20876-20b. Place of Disposition (Name of cametery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition Mar 29 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2007 permit. Page Department of Important: If any Injury or once. 4 Donation 5 Other (Specify) M00382 22 App a Funderad Family remation Services 21. Signature of Funeral Se 933 Gist Ave. Silver Spring, Maryland 20910-Mut Toluman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Non Small Cell Cancer of the Lung resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 128 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nars! Diractor: A filled in by the fu М 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nam D61083 3-28-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul M. Thambi MD 9707 Medical Ctr Ste 300 Rockville MD 20850 32. Figistrar's Signatur 31. Date filed (Month, Day, Year)

State

Registrar

APR 02

2007

			FOI	partment of Health and Nertificate of Death		ene 3. No. 2 11 11 7	10291
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Agnes Donovan		March 29		6:09 A <sup>M</sup>
0	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
-	Franci		Montgomery General Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birtho	Olney ay) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgon 9. Birthp	lace (State or Foreign
	Funeral Director		175-12-7991 1□M 2⊠F 92 Yrs	Months Days Hours Min.	(Month, Day, Y August 23,	1914 Penn	sylvania
١	pul »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	Location		1	0d. Inside City Limits
	ith the Marylar or 28a-f show	ō	1111 1111,	Silver Spring			1 ☐ Yes 2 No
	r 28a-	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
	th with	alD	3320 Chiswick Court, Apartment 2A	20906		United S	
	er dea	Funeral		<ol><li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li></ol>	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
2	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	ite
5	72 hou	ted	15, Decedent's Education 16a. D (Specify only highest grade completed) (0	ecedent's Usual Occupation	kina 16	6b. Kind of Business/Ind	dustry
7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Merkal Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of wor e. DO NOT use retired) eautician	9	Hair Sal	on
7	filed v Hygie other t		9 17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
0	12 should be filed within h and Mental Hygiene. 7 is marked other than ". traumatic event, the Me.	To Be	William John Black	Ethel :	Elizabeth	Strong	
<u>a</u>	2 should and h			ailing Address (Street and Number or Ru			
ב נו	ges 1 and 2 should be filed within 72 hours after death with the Maryle to filed additional benefits and with the Maryle II flem 27 is marked other than "natural" or Items 23a or 28a-f show If flem 27 is marked other than "natural" or Items 23a or 28a-f show of other traumatic event, the Medical Examiner must be notified at			O McAuliffe Drive,		e, Maryland	
5	ages ent of l t: If It		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montg		i1 2,	Bethesda, M	
	permit. Pages 1 and 2. Department of Health at Important: If Item 27 is any injury or other trainones.			22 Name and Address of Facility Ro Rockville Inc. 300	bert A. P	umphrey Fur	neral Home/
ă	permit Depar Impor any Ir		M01433	Rockville, Marylan	d 20850	tgomery Ave	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of)				
	Examiner						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last c				
27.00,	cate be executed obysician and the burial-transit	dical E	C <sub>d</sub>				
00	ntificate ng phys as the	Medi	IF FEMALE:				
ŝ	atth ce attendi for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
ċ	the de	ysic	1 Yes 2 No 9 Unknown 9 Unknown	J Other (specify)			
Ų.	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	by PI	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the	
COIDS	requir een si nould t	ted			1 □ Yes	s 22 √ 0 3 □ Prob	oably 4 □Unknown
ב ב	rsician: The law s certificate has b	Completed			24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
<u> </u>	an: The		25. Was case referred to medical	26. Place of Dea	1  Yes 2 ath (Check only one)		2□ No
>	Physician: r this certificaral director,	To Be	examiner? 1   Yes   Hospital:   Hospital:   Department   2   ER/Outp.	Other		nce 6 Other (Specif	jy)
5	ding Pt J. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Tin (Month, Day Year) Injury (Month, Day Year)	ry Work?	28d. Describe how	v injury occurred	
2	or Attending after death. Director: Afte in by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Stre	eet and Number or Rura	al Route Number,
2	al or / s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  Check only one)				
	To the vithin To the compl	Me	29b. Signature and title of certifier	29c. License number	296	d. Date signed (Month,	Day, Year)
l	O.			D0063196		3/29/07	
	10		30. Name and address of person who completed cause of death (Item 23a) (3)	Per Print) Prilin Driv	e Olue	K dh y	0832
ì	Sta Registr		31. Date filed (Apply Day, Year) 32. Registrar's Signature	we!		l	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2007 **Physician** MARCH 29, MARGARET LOUISE A. DURHAM 8:15a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOMEWOOD NURSING CENTER BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 91 Months Days Hours Min. NORTH CAROLINA Director 243-32-3511 6-24-1915 Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director 1 Nes 2 No MD. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 740 POPLAR GROVE ST. 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural," or iten any injury or other traumatic event, the Multical Exercitions. Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo BLACK Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) -12-DAY WORK DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE S. AUSTIN ELIZABETH AUSTIN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON HASSAN(NIECE) 9203 APPLEFORD CIRCLE OWINGS MILLS MARYLAND 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 □Removal from State GARRISON FOREST VETERANS 4-4-2007 OWINGS MILLS, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee JONATHAN HIENER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an has autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No i or Attend after death. | Director: / 2 Accident investigation completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral DI t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1451CIAN 5-30-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

SANDHU

31. Date filed (Month, Day, Year)

940

W. BALTIMORE ST. BALTIMORE Mp 21223

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

			For 1 _ State	State of Maryland	-			Mental Hy	giene		
r	*	К.	Registrar  1. Decedent's Name (First, Middle, Las.	*)	Cer	tificate of	Death	2. Date of De	Reg. No.	07	10291
	Physici		Lai Mhia	Gaines				Month	Day	Year	3. Time of Death
1	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	h march	4d. County	of Death	0.1
			Lorth west	Hospita	1	Rain	double 1	Dwn	15 G	14:0	noise
	Funeral		5. Social Security Number 6. Se	JM 20XE	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	v. Year)	9. Birthpl Coun	lace (State or Foreign
A	Director		Usual Residence of Decedent	88	115.			Sept.2	1, 1918		Maryland
	yland how at		10a. State 10b. County		Town or Lo					10	0d. Inside City Limits
	e Ma 3a-f s	Director	Maryland Carro	)11	Woodb	ine					1 ∐Yes 2M∭No
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Coun	try?
	death with the Maryland ms 23a or 28a-f show r.must be notified at	Funeral	7331 Donald Court	12. Was Decedent Ever in U.S.	12 1	21797	lon ania Odinia 2/5		USA	Amanda	
0	r item	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 X No	13. V	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black	- America k, White, e	
-0030	72 hours after natural", or ite iical Examine	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2 <b>K</b> INo	Specify:		Specify:	W	hite
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V	filed within Hygiene. Ither than "	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)			)				
מ	filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)		но	memaker	18. Mother's Nar	me (First, Middle,	Own H		
<u> </u>	Ald be fental rked c	To Be	Charles Reben					esa Wimm		-7	
ary	12 should be filed within " h and Mental Hygiene. F is marked other than " traumatic event, <u>the Me</u> c		19a. Informant's Name/Relationship (T)			g Address (Street					
.`	and and marked m		Donna L. Squires	Daughter		1 Donald	Court, V		, Maryla	nd 2	1797
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	Removal from State cen	netery, cren	sition (Name of natory or other plac	· :	Date	20c. Location - 0	City or To	wn, State
	it. Pa intmer intant: injury		4 ☐ Donation ↑ 5 ☐ Other (Specify)  21. Signature of F, neral Service Li ens			en Cemete					e, Maryland
0	permit. Departr Importa any inj		21. Signature of Parietal Service Eleans		Fi	Name and Address	ome of Ca	tonsvil	le, Inc.	cnwai	5 witzke
			23a. Part1. Enter the disease, or compl	ications that caused the death.	Do not ente	630 Edmor er the mode of dyin	ndson Ave g, such as cardiad	enue, Ca	tonsvill rest.		D 21228 Approximate Interval Between
	Physician	i	shock, or heart failure. List only o Immediate Cause (Final disease or condition	The Cause on each line.							Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conse der	nce of):	1 chry	6 692 1	VILLE, VIZ	palmino	y d	figetie.
	Examiner		Sequentially list conditions	o		N				,	
	ted sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):						
<u>.</u>	execur al-trar	xan	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):	<del></del> -				$\dashv$	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed virtin 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical E		1							
9	rtificat ng ph) as th	/ledi	IE EE ME								
Š	ath cer tendir or use	Physician/M	23b. was decedent pregnant	23c. If yes, outcome pf pregnanc 1□Live birth 2□Fetal de		Ectopic pregnancy			23d. Date		•
	ne deg the at hed fo	/sici	in the past 12 months? 1 ☐ Yes 2 Ē No 9 ☐ Unknown	4□Pregnant at time of deat 9□Unknown		Other (specify)			Mon	th [	Day Year
	that the ed by detacl		Part II. Other significant conditions con	ntributing to death but not resulting	na in the un	derlying cause give	en in Part I	23a Did to	haceo use contrib	huta to th	e cause of death?
ה כ	uires n signe Id be	d by		•		and give	art art i	1 🗆 Y	\		ably 4 ∏Unknown
5	tw require s been sign should to	lete			·			24a. Was a	24h W	lere autor	osy findings available
	The lav	Completed						autop perfor	sy pr med? de	ior to com	npletion of cause of
3	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea	1 Yes th (Check only or	$\sim$	☐Yes 2	2 No
5	Physician: The la r this certificate har ral director, page 2	To I	1 ☐ Yes 2 No	lospital: 1 Inpatient 2 ER		3□ DOA Othe	r: 4□ Nursing H	ome 5 ☐ Resid	ence 6 □Other	r (Specify,	)
	ding Phy h.: After thi funeral	ii o	27. Manner of Death  1 Natural 5 □ Pending	28a. Dáte of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occurre	d	
2	vittenc death ctor: y the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At home	farm stra		/es 2 □ No	29f Location (C	A		
2	afor A after 1 Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	or, ractory, office	Į.	City or Tow	treet and Number n, State)	or Hurai	Houte Number,
	pspita hours unera ly fille		29a. Certifier 1 Certifying Phys	siclan: To the best of my knowle	dge, death	occurred at the tim	ne, date and place	, and due to the o	cause(s) and man	ner as sta	ated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examination and manner stated.	n and/or inv	estigation, in my op	oinion, death occu	rred at the time, o	date and place, ar	nd due to	the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	17:1		29c. License	number	2	29d. Date signed	(Month, D	lay, Year)
			Alice 1-	1 ruel		144	3774	h	word 2	= Y	500)
			30. Name and address of person who co	mpleted cause of death (Item 23	Ba) (Type, P	rint)	1 6	1.11.0		, -	/ /
Α	Stat	te	31. Date filed (Month, Day, Year)	3 Registrar's Signature	1	1011 to	1 /00	nk lleto	sh. 12	10-11	1 Bud
	Registra		APR 0 2 200	7 Doew J.	Goa					,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** alton 30 10:00 0 /Medical ames 4c. County of Death Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner nter If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) 1 M 2□ F Months Days Hours Min. Yrs Director MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r 28a-f show notified at 10a State 10d. Inside City Limits 1 ☐ Yes 2 🖼 No Directo MO 10e. Street and Number 4 10f. Zip Code 10g. Citizen of What Country? 206 "natural", or items 23a or Funeral 215 nitec mer 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: þ 3 ☐ Widowed 4 ☐ Divorced SIACK Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical I Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nfant none 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Hanover Street Baltimore, MD Harbor Hospital Center 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other(Specify) in state algnature of Euneral Service Sicensee Wade State Anatomy Board 655 W. Baltimore Street Dixector Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EX TREME REMATURITY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the bunal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy n the past 12 months? 1 □ Yes 2 □ No Day 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2☐No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: . 2□ No Other: 1 hpatient ဥ 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Accident 5 Pending investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10058716 MARCH 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar APR 0 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore MONIUM 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV, 12, 192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Security Number 6. Sex **Funeral** Min 1□M 2 1 F Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f ahow or other traumatic avent, the Madical Examiner must be nutified at 1 XYes 2 □ No Itimore Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Sprin9 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. or itams 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. important: if time 27 is marked other than "na any injury or other traumatic avent. Balto City Dept. of Social Services Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VIOLGAN ones Vnie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 200 5 4 ☐ Donation 5 ☐ Other (Specify) oodlawn (emeteri 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Hom 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned hours and in the contractor. completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 1 Yes P.O. 9 Unknown 9 Unknown ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Loth ritis 3 Probably 4 Hinknown 1 Yes 2 No 52cmon 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) Mile of certifier 29c. License number 29b. Signature and 07 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 3 Registrar's Signature State APR 0 2 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 23, Loretta Madeline Hissey 2007 9:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5944 Baltimore Street Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 1, 1921 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ☐ ¥F Yrs. Director 212-14-3108 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 ehow eny injury or other traumatic event, Ita Medical Function 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5944 Baltimore St. 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Schultz Brown J. Loretta Lawrence ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 Misty Meadow, Sykesville, MD 21278 Roberta L. Gemmell (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3/28/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician o Car disease or condition resulting in death) /Medical Due to (ocas a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included successions) Due to (or as a consequence of). Examiner death certificate be executed ettending physician and for use as the burial-transit rethat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e 1 Yes 25 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 No 3 Probably 4 Unknown peeu a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has perform 200 7 ☐ Yes 1 ☐ Yes 2 ☐ No After this certification To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASTINE TE 100L Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

APR 0 2 2007

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28 LEROY V. HOPKINS /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner V If Under 1 Year | If Under 24 Hrs. Sex 14 M 2 □ F (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) al Security Number 7. Age **Funeral** Months Days Hours Min 212-42-8516 Yrs Director 63 02 - 13 - 1944MD Usual Residence of Deceden death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b County 10d. Inside City Limits M☐Yes 2☐No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be r ns 23a must b 1515 PRESSTMAN STREET Funeral 21217 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or item Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: BLACK 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) BAKER BAKERY 8 other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental lem 27 is marked or JAMES HOPKINS ဥ ROSELLA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 RENEE HOPKINS/DAUGHTER 1527 LESLIE ST., BALTO., MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date ö 5 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ZION 04/04/07 BALTIMORE, MD permit. 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licenses LAURENS ST., BALTIMORE, MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RHUISION disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-trai signed by the attending physician d be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part IL, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Gow 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? Yes 2 No page 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 Yes 2□ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 1 D Natural (Month, Day 5 ☐ Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date-fled (Month, Day, Year) egistrar's Signature State APR 02 Registrar

DHMH 17 Rev 1/2001

timore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year : 25PM /Medical 4a. Facility Name (If not institution, give street and num 4c. County of Death Jown, or Location of Death Examiner moRE 405 If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Social Security Number **Funeral** Age 9. Birthplace (State or Foreign 12M 2□F Months Days Yrs. NEW Director ORK Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medi-al Examiner must be notified at 1 Yes 2 No Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Baco Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BIACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Doivorced 16b. Kind of Business/Industry

RANSP 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) DOLICE /34 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OW5m n 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 0 21. Signatu e of Funeral Service Mens V 2121 P n1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Day Organ disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** scudomona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending for use a IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No be detached 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should I 2 No 3 Probably Completed 11mphomo 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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State Registrar

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31. Date filed (Month, Day, Year)

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Registrar's Signature

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Maryland	S D E E	_	19a. Informant's Name/Relationship (Type	oe, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	il Route Numb	er, City or To	own, State, Z	ip Code)
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)	\		Miles I RIG	Intro	MO		/	232	3/1	6		03	30	2007
21	\\/		30. Name and address of person who co	mpleted cause of	death (Item 23	Ba) (Type.	Print)				, -			,
1	A		Michele F Bellento.	" no 10	5503	- Ho	Kin.	Rose	was I	Del.	Ra	162-0	· m	2007 D 21224
	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signatur	1 4	rede	1	~	/ (		117751		
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			1 - For State Registrar	te of Marylan		artment of Hotilicate of L			giene	7	0301
	<b>D</b>		Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		Henrietta Hudson					March	20 2	007	10:52p M
188	Examin	er	4a. Facility Name (If not institution, give street a			4b. City, Town, or		ith	4c. County	y of Death	,
		. T	Good Samaritan Hosp: 5. Social Security Number 6. Sex	ital 7. Age (In yrs. i	last hirthday)	Balt:	If Under 24 Hrs	s. 8. Date of Birt	th	9 Birtholar	ce (State or Foreign
	Funeral Director		231-20-0713  Usual Residence of Decedent			Months Days	Hours Min		y, Year)	Country	w unk
	yland yland		10a. State 10b. County	10c. City	y, Town or Lo	cation				100	d. Inside City Limits
	e Mar	ctor	MD		Balt	imore					1√ Yes 2 No
	vith th	Funeral Director	10e. Street and Number 5009 Frankford Avenu	10		10f. Zip Code	206		10g. Citizen of	What Country	λ.
	eath v	era		us Decedent Ever in U.	S 13 V			Specify Yes or No		ce - American	ı Indian.
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "natural", or Items 23a or 28e-f ehow event, the Madiral Extrainer rust be notified at	by Fun	1 Never Married 2 Married 1 [	med Forces? ]Yes 2 [ANo 'es, Give ar or Dates:	1	Was Decedent of His f Yes, specify Cubar I □ Yes 2X No	Specify:	nto Rican, etc.)	Bia	ck, White, etc fy: blac	c.
5-0036	2 hour		15. Decedent's Education		16a. Deced	lent's Usual Occupa	tion	unk	16b. Kind of E	Business/Indu	stry unk
212	- 64	ple	(Specify only highest grade comp Elementary/Secondary (0-12) Co	oleted) llege (1-4or 5+)	(Give life. I	kind of work done d DO NOT use retired)	uring most of wo	orking			
212	filed within Hygiene. sther then "	Completed	unk unk	,							
<u>n</u>	be fill of oth	Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	ame (First, Middle,	, Maiden Sumai	me)	unk
Maryland	S should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mematic event ev	은	19a. Informant's Name/Relationship (Type, Pr.	int)	19b Mailir	ng Address (Street a	nd Number or F	Bural Route Numbe	er. City or Town	State. Zip C	Code)
<u>8</u>	and 2 sho ealth and n 27 is m		Good Samaritan Hospi			Loch Rave				21239	
altimore,	of Hei		20a. Method of Disposition  1 Burial 2 Cremation 3 Remove	20b. P	lace of Dispo	sition (Name of natory or other place		Date	20c. Location		n, State
Baltir	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee Wade			Name and Addres ate Anato			Baltim	ore St	reet
	Physician		23a. Part1. Enter the disease or complication shock, or heart failure. List only one cau Immediate Cause (Final	s that caused the death se on each line.	n. Do not ent		, such as cardia	ac or respiratory a	rrest,	1 1	Approximate nterval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		(200)	4.092	VICINA	<u> </u>		11/000
	* 8 - 3	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):						
,09/	ate be executed hysicien and the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events c	Due to (or as a consequ	uence of):		<del></del>				
289	ficate physis ts the	edlc	d								
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months?	res, outcome of pregna ]Live birth 2 ∏Feta ]Pregnant at time of di ]Unknown	Ideath 3	Ectopic pregnancy Other (specify)				ate of delivery onth D	/ Day Year
7	ires that the de signed by the a f be detached f	þ	Part II. Other significant conditions contribution	fension	ulting in the u	nderlying cause give	n in Part I.	23e. Did t		ntribute to the	cause of death?
Ö	w require been si	etec	1/9//	Jens Lore				24a. Was		Ware autons	sy findings available
al Records,	siclan: The lav certificate has rector, page 2	Completed						autor	psy ormed?	prior to comp death?	pletion of cause of
<u> </u>	siclan: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	di . Elemina o Est	50.0	. 20 DOA Othe	ır	eath (Check only o			
n of	ding Phys h. After this funeral di	on: To	TE THE ZE NO	1 ☐ Inpatient 2 ☐ Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	at	Home 5 Resident	dence 6 ∐Ot how injury occu		
Division of Vital	or Attendi fler death. Sirector: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At he building, etc. (Specification)	ome, farm, str		res 2 □ No	28f. Location (. City or Too	Street and Num wn, State)	ber or Rural I	Route Number,
_	To the Hospital or Attanding Physician: within 24 hours elter death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical Ce	29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner: 0	n the basis of examina							
	o the o the omple	Mec	29b. Signature and title of certifier	nd manner stated.		29c. License			29d. Date sign		
	⊢≯⊢ŏ		Kunush Alas			73	8543				
			30. Name and address of person who complete	ed cause of death (Item	n 23a) (Type,	Print)	3		D /	~	Janjana (
16	Sta	ate_	KEVIN If. Strings. 31. Date filed (Month, Day, Year)	MA) 56 32. Registrar's Signa	iture _	och fave	a Boul	terend 1	Bilhin	ore it	longland
	Regist		APR 0 2 2007 &	ener &	Masse	1					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Betty Jane Haugh /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 317 S. Potomac Street Apt 1 Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday **Funeral** 1 M 2 X F 220-18-1878 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 271s marked other than "natural" or Health any injury or other fraumatic. 10a. State 10c. City, Town or Location 10b. County MD Washington Director Hagerstown 10e. Street and Number 10f. Zip Code 317 S. Potomac Street Apt 1 21740 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) frozen food manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Edward Fahrney Daysye Amelia Bragunier 19a. Informant's Name/Relationship (Type. Print) Earl Williamson/son 611 N. High Street Martinsburg, WV

16b. Kind of Business/Industry grocery store

2. Date of Death

March 28.

8. Date of Birth (Month, Day, Year)

Aug 20, 1926

Day

2007

4c. County of Death

10g. Citizen of What Country?

Washington

Maryland

14. Race - American Indian, Black, White, etc.

25404

20c. Location - City or Town, State

Specify: White

10:50 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice RODALO S Wade, Directo

<sup>22</sup> Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part1. Enter the disease, or complications that cause in shock, or heart failure. List only one cause on each line. Immediate Cau (Final disease or condition resulting in death)

LARDNY CARCINOMA Due to (or as a consequence of):

Onset and Deat
 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Due to (or as a consequence of)

3 Ectopic pregnancy

23d. Date of delivery

Month Day

23b. Was decedent pregnant in the past 12 mon 1 ☐ Yes 2 ☐ No 9 Unknown

IF FEMALE

4□Pregnant at time of death

5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

he death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Nonknown

Year

Approximate

24a. Was an autopsy performed 2 🕞 26. Place of Death (Check only one

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case	referred to medica
examiner'	?
1 ☐ Yes	2

27. Manner eath 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

2 ☐ ER/Outpatient 3 ☐ DOA 1 TInpatient 28a. Date of Injury (Month, Day Year)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at Work? Injury 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0001040

03-29-2002

29d. Date signed (Month, Day, Year)

COHEN 31. Date filed (Month, Day, Year) APR 0 2 2007

29b. Signature and title of certifier

322 €. ANTIE DAM ST. 32. Registrar's Signature

State Registrar DHMH 17 Rev 1/2001

within 2 To the I

**Physician** 

/Medical

Examiner

Physician/Medical

ò

Completed

Be

Certification:

Medical

page

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician q certificate this After t in 24 hours after continues the Funeral Director: Af

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

1. Decedent's Name (First, Middle, Last) Day **Physician** Darla Mae Ireland March 30, 2007 11:58 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 😿 F Director 213-36-5987 67 May 25, 1939 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ıral", or Items 23a or 28a-f shov Exa<u>mlner must be notified at</u> 1 ☐ Yes 2 No Carrol1 |Maryland| Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2067 Misty Meadow Road 21048 IISA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White ģ 3 Widowed 4 Divorced 'natural' Completed Ith and Mental Hygiene.
77 is marked other than "nature traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dental Assistant Dentistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henderson Ida Mason 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip E. Ireland Husband 2067 Misty Meadow Road; Finksburg, Maryland 21048 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Garrison Forest 4/5/2007 Owings Mills, MD 4 □ Denation 5 ☐ Other (Specify) of Funeral Sei 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, tease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the d shock, or heart fa Immediate Cause (Final **Physician** months arunoid disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1,230Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide PECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral D

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles ST TOWEN NO 2(204 Charles mo Apron J 6701 N. 32 Registrar's Signature 31. Date filed (Month, Day, Year)



State Registrar

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year Johnson Month 7 **Physician** 6:40 PM VIN 2007 28 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimica Year If Under 24 Hrs. Hays Hours Min. Baltimore Macyland Medical Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Funeral Months Days Director Marylan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In wit: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No Completed by Funeral Director altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ISA Hvenue 1013cm5 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced lach 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bu ess/Industry Elementary/Secondary (0-12) College (1-4or 5+) Otal ears Healthcare 18. Mother's Name (First, Middle, Maiden Surname) To Be ( 17. Father's Name (First, Middle, Last) Johnson, Sr. Horne M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 82 Yarsons Avenue Daltimore MO 21207 Hnaela Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03.03.2007 Bultimon, mo codlain 22. Name and Address of Facility Vough C. Creine furral Service 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iberty hoad Mandallesten mo 21133 Approximate Interval Between Onset and Death Immediate Cause (Final Physician days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lediastinit Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and Esechases Due to (or as a consequence of): that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical orrhagre IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has autopsy pertormed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed s after deau...
ral Director: After this cer.... completely filled in by To the Hospital of within 24 hours at To the Funeral C

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number AU4176435 29d. Date sinned (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kristian 3-47 77

MD 21261

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year)



07-02301	
Frank W.	

07-02301		Ple	ease Ty	pe or Print	in B	lack Inc	delible l	nk. Ens	ure A	All Copi	es Are L	.egibl	le.		
Frank W. Janow	ich,	Jr 1- For State	S	tate of Mary	land	/ Depar	tment o	f Health	and N	Mental F	lygiene		20		1630
Physicia	ın/	Registrar	ne (First, Mide	dle Last)		Cert	ificate o	f Death			2. Date of D	Reg. No	o	UI	3. Time of Death
Medical Exami				nowich,	Jr						Month March 2		Year		1747 hrs
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Baltimo permit Pag Department Important:	-	4 Donation 5 21 Signature of Fu				Che		ake Cr							e, MD
Balt permit Depart Impor injury		21 Signature or Fu	Service	R	M	111112				0.1	emati	on	And I	run	eralBAlto
Physician		23a. Part I. Enter th	ie disease, or	complications that	caused	the death. D	o not enter the	terna	ing suct	as cardiac d	r respiratory	arrest sh	Pasi lock or hear	inc h	Approximate Interval
/Medical Examiner	1	23a. Part I. Enter the failure. List on Immediate Cause (	Final disease	a. Hyperte	cain nsive	e and p cather	ropoxíh sclero	ene ic card	iovas	cular d	isease				Between Onset and Death
		or condition resulting	ng in death)	Due to (or as	a conse	equence of);									
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):													
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a-B	흲	X UNPENDED		X #Z3a,P	$\overset{\#2}{\coprod},\overset{3}{\cancel{27}}$	,27,28a ,perÆ,	-1, pen , g866,	ME, g866 4/6/07 ]	), 4/2 IT	23/07 TI					
Box 68760, e death certificate be exthe attending physician ed for use as the burial		IF FEMALE: 23b. Was decedent past 12 months	pregnant in th	ne 23c. If yes		ne of pregnar		tal death	3 E	ctopic pregna	ancy	23	d. Date of de Month	eliv <b>e</b> ry Da	ay Year
ox 6 ath cer attendi	Sicia	1 Yes 2 N		known I ' 🖂		time of death	· =	ner (Specify)			•				,
D. B.	吾	Part II. Other signi:		9		but not resu	ulting in the u	nderlying cau	se given	in Part I.	23e. Dio	tobacco	use contribu	ute to th	ne cause of death?
ires that the signed by the detach	함	Chronic a	active h	nepatitis, o					J		1 🔲 Y	res 2	No 3	Proba	ably 4 🗸 Unknown
ords	흥  										24a. Wa	as an topsy			opsy findings available ompletion of cause of
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start cleath.  The ster death.  Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director.	Completed										per	rformed?	de	ath?	
Vital Reorginists The his certificate director, page	Be	25. Was case referrexaminer?	ed to medica	Hospital:						eath (Check	only one)				
n of Vi ding Physi After this funeral dir	의	1 Yes 27. Manner of Deat	2 No	28a. Dat			R/Outpatient 8b. Time of Ir		Othe Injury at '		ng Home 5			Other:	
on C ending ath. or: Af	틹	1 Natural	5 Pend	ding Fnd	th, Day,Y	ear)	Fnd 5:00			2 <b>X</b> No	unk.	o non m	ary documen	•	
Division pital or Attend ours after death eral Director:	ertification:	2 Accident 3 Suicide	6 X Coul	stigation				et, factory, office	ce buildir	ng, etc.	28f. Location		and Number	or Rur	al Route Number, City
Spital Spital Hours a neral	( ) F	4 Homicide	dete	rmined (Specify	) Ho	use				13	or Town	orth A	venue,	Balt	imore, MD
	न्न			hysician: To the be miner:On the basis											
To To	ĕŀ	29b Signature and		and manner	stated.				ense nur						h, Day, Year)
Year.		au	est					0.	C.M.E				rch 26, 20		
10/4	t	30. Name and addre		· ·		,	,								
0		Ana Rubio N	ID. Ass	sistant Medical	m			treet, Balti	more,	MD 2120	1				·
Sta Registr	te ar	31. Date filed (Mont	PR 02	2007	tegistrar	's Signature	Ans	we							

			1 - State of Maryland / Dep Registrar  State of Maryland / Dep	artment of Health and Nartificate of Death		ene 1. No. 2007 10306
,	Physici /Medic		Decedent's Name (First, Middle, Last)  Jean Ethel Lutz		2. Date of Death Month March 20	Day Year 3. Time of Death 2:15 AM M
	Examir		4a. Facility Name (If not institution, give street and number)  1007 Chesapeake Drive	4b. City, Town, or Location of Death Stevensville		4c. County of Death Quuen Anne
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 K F  7. Age (In yrs. last birthday of the second seco	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y	year) 9. Birthplace (State or Foreign Country) Maryland
saitimore, maryiand 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hyglene. Deperment of Health and Mental Hyglene. Introortant: if Item 27 is marked other then "natural; or items 23s or 28s-f show any highly or other treumatic event, the Medical Exemplar mastice notified at DDCs.	To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes, Sive Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) unk  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Print)  Queen Anne Hospice  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 XDonation 5 Other (Specify)	SVII1e  10f. Zip Code  21666  Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼ No Specify:  Indent's Usual Occupation a kind of work done during most of work done during most of work DO NOT use retired)  Unk  18. Mother's Name and Address (Street and Number or Running Address (Street and Number o	pecify Yes or No- partial Policies of Rican, etc.)  It is a second of the control of Rican, etc.)  It is a second of Rican Ric	City or Town, State, Zip Code) unk
,0070	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	y Physician/Medical Examiner		NE HEART  ARTERI  Description of the respective	FALUE PDISC	Approximate Interval Between Onset and Death O
ivision of vital necords,	ng Physician: The lar fter this certificate has ineral director, page 2	Certification; To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No	nt 3 DOA Other: 4 Nursing Ho  28c. Injury at Work?  M 1 Yes 2 No	th Check only one) ome 5 Residence 28d. Describe how	te 6 □Other (Specify) injury occurred  at and Number or Rural Route Number.
2	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai Cer	29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or in	h cocumed at the time, data and ideas	and dua to the caus	paral man tax as etatod
)	To the within To the comple	Mec	29b. Signature and time of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		i	30. Name an lattress of person who completed cause of d ath (Item 23a) (Type, VARICA A. BOWKR MD M.	Print 115 SAllit 1 Stevens Vi	DRIVE UE MI	) 216do
į	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 2 2007  32 Registrar's Signature	المان		

			1 - For State Registrar	State of Mary			ent of H		d Mental H	ygien Reg. N	2111	37	0	307
	Dhyaiai	-	1. Decedent's Name (First, Middle, Las	,					2. Date of D Month	eath	ay	Year	3. Time o	of Death
	Physici /Medi		Frank, Le						03	2	N -	2007	180	3 M
	Examir	ner	4a. Facility Name (If not institution, give		~~	4b. Ci		Location of De	eath .	4	c. County	of Death		
			Mercy Med 5. Social Security Number 6. S		yrs. last birthday	150	ler 1 Year	10 /C	frs. 8. Date of B	inth		O. Dieth -	In an /Canan	(°i
н	Funeral Director			KTIM OFF	8 Yrs.	Month			lin. (Month, D	) 19	38	Coun	lace (State try)	unk
	P		Usual Residence of Decedent						1,0 , ,	,				
	ehov	٦	10a. State 10b. County MD	100	c. City, Town or L Baltim							10	Od. Inside C	
	289-f	Director	10e, Street and Number		Daltill		Zip Code			10- 0	(A) 4 M	10		2 □ No
	3a or		1255 S. Hanover	Street		101. 2		1230		10g. C		Vhat Coun	iry ?	
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õ	hours after death with the Maryland turel', or iteme 23a or 28e-f ehow at Examinar must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	unk	_	респу Сира 2 <mark>∭</mark> No	n, Mexican, Pu Specify:	erto Hican, etc.)			k, White, e		
ğ	hours lurel',	d by	3 Widowed 4 Divorced	Year or Dates:					1170			whi	.*	1-
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Maryland	12 short and reum		19a. Informant's Name/Relationship (7						Rural Route Num			State, Zip	Code)	
യ്	s 1 and 2 should if Health and Men Item 27 ie marke other treumatic		Mercy Medical Cer  20a. Method of Disposition		30 Ob. Place of Disp			l Place	Baltimo Date			21201	Ctata	
و	Pages nent of int: If it		1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory o	other place	9)	Date	20C. L	Location -	City or Tov	vn, State	
altimore,	permit. Pages Department of I Important: If It eny injury or or once.		4 □ Donation 5 ☑ Other (Specify 21. Sign the e of Funeral Service Licen	see	_2	2. Name	and Addres	s of Facility						
ñ	Ded July Person		Monard S.	Wade, lirect	or St	tate	Anato nore,	my Boa:	rd 655 W. 201	• Bal	ltimo	re St	treet	
			23a. Part. Enter the disease, or composition or heart failure. List only	olications that caused the	death. Do not en	ter the m	ode of dying	, such as card	iac or respiratory	arrest,			Approximation	te tween
ķ.	Physician		Immediate Cause (Final disease or condition	. Card	iomyo	Pat	hu					,	Onset and	
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٥	ertific ding pl	Med	IF FEMALE:							- 1				
X02	eath c attenc for us	lan	in the past 12 months?	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time	Fetal death 3		pregnancy				23d. Date Mor	e of deliver	•	Year
j.	the di y the iched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ordeath 5t	Other (	sреспу)						1	
Ž.	w requires that the death certific been signed by the attending p should be detached for use as	y P	Part II. Other significant conditions co	ontributing to death but not	t resulting in the u	nderlying	cause give	n in Part I.	23e. Did	tobacco	use contr	bute to the	e cause of o	death?
ğ	en sig								10	Yes 2	No	3 🗌 Proba	ıbły 4 ⊟i	Unknown
ecords	law re as be 2 sho	Completed							24a. Wa:		24b. W	Vere autop	sy findings	available
	sician: The law s certificate has b lirector, page 2 s	Con							- auto perf 1 ☐ Yes	ormed?	d	eath?	npletion of c 2□ No	2050
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5	> ~ 0	<u>د</u>	1 ☐ Yes 2 No  27. Manner of Death	1 Minpatient	2 ER/Outpatier 28b. Time o	_		4   Nursing	Home 5 ☐ Res				,	
DIVISION	ding th. tate	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	r) Injury	м	28c. Injury Work 1 □ Y	ai ? ′es 2∐No	28d. Describe	now inju	iry occurre	<b>9</b> 0		
<u> </u>	Atter or dea ector by the	Ifica	3 Suicide 6 Could not be		At home, larm, str				28f. Location	(Street ar	nd Numbe	er or Rural	Route Nurr	nber,
5	taior rs afte el Dir ed in	Certification:	4   Nothicide	building, etc. (Sp	өсігу)				City or To	wn, State	e)			
	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a Certifier 1 Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exam and manner stated.	knowledge deat mination and/or in	h occurra vestigatio	d at the tim n, in my op	a, date and pla inion, death oc	ce, and due to the curred at the time,	cluse(s date an	d place, a	nar as sta nd due to t	led. the cause(s	s)
	o the	Med	29b. Signature and title of certifier	and manner stated.			9c. License					(Month, D		
	> 0		· ~				P2	1181			,		2007	-
		1	30. Name and address of person who c	ompleted caused death	(Item 23a) (Type,	Print)					/	-/-		
			Many Chung	, MD. 301	St. Pac	117	lace	Bal	bmore	, ~	112	2120	2/	
	Sta Registr		30. Name and address of person who come the common of the	32.75 distrar's S	ignature	evi	9							

	(5), 5			1 - For State Ragistrar	State of Marylar		tment of He			ene 1. No. () ()	Parameter I	10308
	"	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last, Elizabeth Ann 4a. Facility Name (If not institution, give	Mach		b. City, Town, or L	ocation of Death	2. Date of Death Month HARCH	Day 23 2 4c. County	Year 9007	3. Time of Death $2:24p$ M
	F	uneral	ler	G60d Samaritan  5. Social Security Number 6. Sec	n Hospita	last birthday)	Baltiv	UOV2 If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	NA 'ear)	9. Birthpi Coun	
	3.37	irector		Usual Residence of Decedent  10a. State 10b. County	, ,	ty, Town or Loca	tion		may 12.	1925	Chi	Od. Inside City Limits
	h the Mary	r 28a-f show	Irector	10e. Street and Number		Balti	moye 10f. Zip Code		10g	. Citizen of W	/hat Coun	1 <b>X</b> ÎYes 2 □ No
	d 21215-0036 filed within 72 hours after death with the Maryland Hyolene.	rthan "natural", or itema 23a or 28a-f ebo the Medical Examinar must be notified at	Completed by Funeral Director	3308 Tioga Pa	12 Was Decorated Ever in I	J.S. 13. Wa	212/ s Decedent of Hisp es, specify Cuban,	5 panic Origin? (Spe Mexican, Puerto	ecity Yes or No-Rican, etc.)		7 • Americ k, White, 6	
×	-0036 hours afte	tural', or li al Exemin	ed by F	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	10		Specify:		Specify	Bla	CK
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+	Maryland d 2 should be file	is marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last)	sey			1 0	(First, Middle, Ma			
ZABETI	E E	item 27 is marked other other traumatic event,	-	19a. Informant's Name/Relationship (Ty Percy D. Mach 20a. Method of Disposition	150n	19b. Mailing	Tioga 7		Baltir	nore,	mo	21215
ZM	Baltimore	rtant: If njury or		Burial 2 Cremation 3 R     Donation 5 Other (Specify)  21. Signature of Funeral Service Ligns:	emoval from State	uid Mi	ory`or other place)	04 0	3/07/	c. Location • (	le n	ND
ELJ.	Balt permit.	Impo eny ii		23a. Part 1. Ent of the disease, or complishock, or heart failure. List only or	CLNL cations that caused the deal e cause on each line.	h. Do not enter	128 L. be he mode of dying,	rty Docu	uck <i>Nocond</i> or respiratory arrest	allota	n m	Approximate Interval Belween Onset and Death
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	8760, Æ ate be executed	ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or as a consec							
	<u>ڇ</u>	g phys as the			_					1127	Approximation in the second	
	Vision of Vital Records, P.O. Box 6: Attanding Physician: The law requires that the death certific death.	To the Funeral Director: Atter this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 moinths? 1 □ Yes 2 12 No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il death 3 □Ed	topic pregnancy ther (specify)			23d. Date Mon	of deliver	ry Day Year
	rds, P	n signed b		Part II. Other significant conditions con END STALE RENI	tributing to death but not res	_	rlying cause given				bute to the	e cause of death?
	Division of Vital Records, P.O. for Attanding Physician: The law requires that the de after death.	ate has bee page 2 sho	Completed by	CORDNARY ARTE	RY OISEAS	<u></u>			24a. Was an autopsy performed	24b. W pr d? de ] No 1	lere autoprior to coneath?	osy findings available inpletion of cause of
	f Vital	his certifice I director, p	To Be C	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \)	ospital: LaInpatient 2	ER/Outpatient	2 3 DOA Other:		(Check only one)			
	ision o	tor: After the the funera	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		t 2 s 2 □ No	28d. Describe how			
	Division To the Hospital or Attention Within 24 hours after death	illed in by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifician: To the best of my known in the second second second second second second second second second second second second second second second second second second seco	y) 	-		City or Town, S	State)		Route Number,
	o the Hos	o the Fun	Medical	(Check only one) 2 Medical Examir (Check only one) 2 Medical Examir (Check only one) 29b. Signature and title of certifier	er: On the basis of examina and manner stated.	ition and/or inves	agation, in my opin	ion, death occurre	ed at the time, date	and place, a	nd due to	the cause(s)
	- 3	Λ		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, Prii	RESO		H	ARCI	+ 29	2007
		Sta	te	31. Date filed (Month, Oay, Year)	AN HOSPI	TAL 50	ol Loci	+ RAVE	NBLV	'AB!	BALTI	MORE HAS

				icase i	ype or Print in i			-		
			for Stata		State of Marylar			l Mental Hygie	ene	478
			- Stata Registrar			Certific	ate of Death	Reg	. NO UU / 1030	9
	Dhuala		Decedent's Name (First	, Middle, Last	)			2. Date of Death Month	Day Year 3. Time ol Death	1
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			BALTIMOR	E REI	HABILITATA	WESTE	WIDEN CAR	C BALTICA	OF E	
	Funeral		5. Social Security Number	6. Se:		last birthday) If Ur Mont	der 1 Year If Under 24 H	rs. 8. Date of Birth	9. Birthplace (State or Fore Country)	ign
	Director		420-64-636	6	60 EM 20 F	Yrs.	is Days Hours M	rs. 8. Date of Birth (Month, Day, Y	947 COUNTY AL	
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	aryla sho	_	Toa. State	County	100. CI	ty, Town or Location			10d. Inside City Lim	
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:	vith t	Director	10e. Street and Number	11	W. Dr. A.	101.	Zip Code	10g	Citizen of What Country?	
	be filed within 72 hours affer death with the Maryland ital Hygiene. I have the than "natural" or fems 23a or 28a-f show dother than "natural" or fems 23a or 28a-f show svent, it a Mudical Examinar must be notified at	Funeral		ore No		105	21229		USA	
	er de	une	11. Marital Status		12. Was Decedent Ever in U Armed Forces?	.S. 13. Was De	cedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	s aft	by F	1 Never Married 2	_	1 XYes 2 □ No If Yes, Give	1 □ Ye	s 2 No Specify:		Specify: Dlag 14	
21215-0036	tural	pa			Year or Dates:	160 Danadania I			DIUCK	
15	"na"	lete	(Specify only	ecedent's Edu highest grad	le completed)	16a. Decedent's L (Give kind of	isual Occupation work done during most of w Tuse retired	orking 16	b. Kind of Business/Industry	
12	than than	Completed	Elementary/Secondary (	0-12)	College (1-4or 5+)	/	2501-6		Mt. Manor	
	filed with Hygiene. other than		17. Father's Name (First, M	Aiddle, Last)	2412	Cou		ame (First, Middle, Ma		
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	of Health item 27 I	1	20a. Method of Disposition	· Advitte	amsionsters	Place of Disposition (		d. Baltin		-
jo	0 = 5		1 XBurial 2 ☐ Crem	nation 3 🗆 🗗	Removal from State	emetery, crematory c	or other place)	1 - 1	c. Location - City or Town, State	
#			4 □Donation 5 □O			arrison t	orest 4	4 2007	wings Mills, OND	ĺ.,
Baltimore,	permit. Pag Department Important: I sny Injury o once.		21. Signature of Funeral S	ervice sicense	<b>U</b>	* OTT	an Address of Facility	ege Funer	al Services	
	a		laugh	<u>. ن ر</u>	rece	551	Batto, Nat'	Pille, Ba	to-, MD 21229	
4			23a. Part1. Enter the dise shock, or heart failur	ase, or compli B. List only or	ications that caused the deat ne cause on each line.	h. Do not enter the n	node of dying, such as card	ac or respiratory arrest	Interval Between	
P	hysician	ĺ	Immediate Cause (Final disease or condition		AMYNT	ROPHI	· /ATE	PAI SP	Onset and Death	
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Вох	andir use	Physician/Med	IF FEMALE: 23b. Was decedent pregn.	ant 2	3c. If yes, outcome of pregna				23d. Date of delivery	
<b>m</b>	d for	Cia	in the past 12 months 1 Tes 2 No	?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		pregnancy (specify)		Month Day Year	
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0	raw requires that the death certifical as been signed by the attending ph 2 should be detached for use as the	by P	Part II. Other significant c	onditions con	ntributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?	
rds	n sig	d b	HEPA	TITI	PP			1 🗆 Yes	2 No 3 Probably 4 Unknow	vn
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o d	r this ral dii	- To	1 ☐ Yes 2 😿 No 27. Manner of Death		1 Inpatient 2 2	28b. Time of	4/25/vursing		e 6 Other (Specify)	
Division of	After funer	Certification:	1 Natural 5 🗆	Pending investigation	(Month, Day Year)	Injury	28c. Injury at Work?	28d. Describe how	njury occurred	
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S S	Direction of the property of t	i i	4 Homicide	determined	building, etc. (Specify	/)	ory, office	City or Town, S	t and Number of Rural Route Number, Itate)	
- 6	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral		29a. Certifier	rtifying Dh	ician: To the heat of mustice	wladao daeth	and at the time date and t		-10	
Š	Fun Fun tely	edical	(Check only 2 Me	dical Examir	sician: To the best of my kno ier: On the basis of examinal and manner stated.	tion and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
4	thin o <b>th</b>	Mec	29b. Signature and title of	certifier	and mainler stated.		29c. License number	P06.	Date signed (Month, Day, Year)	
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7	1	-		V 24	- work		12464	8 0	5-24-200	
	1	Ì	30. Name and address of p	erson who co	mpleted cause of death (Item	23a) (Type, Print)	CH KMEN	1 17000	ADJUTE MO	
l code	- T- 1		31. Date filed (Month, Day,	Year	2. Registrar's Sigra	Tura de la	1 MICA	DUI)	BITH WILL AR	10
- CAR	Sta	te ar	APR (	2 2007	Places J.	The same				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g866 4-2-07 vt.
State of Maryland? Department of Health and Mental Hygiene? For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 2007 10:58 p м 03 Reita Geraldine McElwee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Maryland Masonic Homes Cockeysville If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Yrs. 03/01/1908 West Virgnia Director 234-32-3971 99 Usuel Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 Is marked other then "naturel", or Items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Directo MD Cockeysville Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21030 300 International Circle U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌂 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: <u>۾</u> 3 X Widowed 4 ☐ Divorced White leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compl College (1-4or 5+) Elementary/Secondary (0-12) Department Store 12 Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be May Elizabeth Jack Dillie H. Welch P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29582 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n eny injury or other traum once. 5650 Barefoot Resort Bridge Rd. N. Myrtle Beach, SC Richard L. McElwee, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park 04/02/2007 \* 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Masandnas Botes 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 9tage **Physician** disease or condition resulting in death) End /Medical Due to (or as a consequence of) Examiner A Than Schoolin. secro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Advaned resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 XUnknown 24a. Was an autopsy performed? 1 ☐ Yes 2 Z No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 You lutes this certificate Attending Physicien: After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident filled in by the within 24 hours after deall To the Funerel Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

5

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Restrar's Signature

Maryland Masonic Homes Cockeysville, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 0 2 200

Robert T. Liberto

31. Date filed (Month, Day, Year)

D21464

3-30-67

		1 - For State Registrar	State of Maryland	l / Depa		ealth ar	nd Mental Hy	giene	07	10311
Physic		Decedent's Name (First, Middle, Last)	and the Tra				2. Date of De Month		Year 3	3. Time of Death
/Medi Examii		Edmund Joseph Melle  4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or				y of Death	1.00
Funeral Director		5. Social Security Number 6. Sex 216-42-0321	Road  7. Age (In yrs. Ia  M 2□ F 64	st birthday) Yrs.	21228 If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da		9. Birthplace Country) Maryla	e (State or Foreign ) and
		Usual Residence of Decedent  10a. State  10b. County		Town or Lo	cation		000.2	, 1512		. Inside City Limits
ith the Ma or 28a-f s	Director	Maryland Baltimore  10e. Street and Number		Ca	tonsville 10f. Zip Code			10g. Citizen of	What Country	1 □ Yes 2 및 No ?
perfullible; Mail yialing 4.1.1.3-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it whedical Evant actional be notified at 2008.	Funerai	51 Edmondson Ridge  11. Marital Status  1 Never Married 2 Married	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No		212  Vas Decedent of His f Yes, specify Cubar  ☐ Yes 2  No		n? (Specify Yes or No Puerto Rican, etc.)		ce - American ack, White, etc.	
n 72 hours a	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	completed)	16a Decec	lent's Usual Occupa	ition	of working 1 Security	Special Specia	Business/Indus	
ild Kithi a filed withi al Hygiene. other than	Be Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Disab	ility Adj	uster	s Name (First, Middle			vernment
Car y car	ToB	Edmund J. Mellend	e, Print)		g Address (Street a	nd Number	e Miller			
ges 1 and 1 tof Health If item 27 or other tr		Kathy P. Mellendic  20a. Method of Disposition  1 (ABurial 2 Cremation 3 Re	20b. Pla	ice of Dispo	dmondson sition (Name of natory or other place nus Cemet	a)	Road; Cat		- City or Town	, State
Dallilli permit. Pa Departmen Important: any injury once.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Foneral Service Licens		22 F	. Name and Addres	s of Facility	Sterling A Catonsvil Avenue; Ca	shton S	chwab 1	Witzke
Le be executed // // // // // // // // // // // // //	cal Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any lise of property of the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	Do not ent		g, such as c			Ar Ini Oi	pproximate tierval Between inset and Death
vical necolous, r.o. box oor stellar. The law requires that the death certificate certificate has been signed by the attending physirector, page 2 should be detached for use as the last the la	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3	Ectopic pregnancy				ate of delivery lonth Da	ay Year
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ysician: 'ysician: 'ysician: 'director, p	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1  Inpatient 2 E	P/Outpatier	it 3□ DOA Othe		of Death <i>(Check only</i> sing Home 5 <b>2</b> Hes		ther (Specify)	
To the Hospital or Attanding Physician: Within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the funeral director.	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \( \)		28d. Describe	how injury occu	rred	Pauta Numbar
pital or Att		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)			o date and	City or To	wn, State)		
To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Medical	(Check only 2 Medicel Examinone)  29b. Signature and title of certifier	er: On the basis of examinati and manner stated.	on and/or in	vestigation, in my op	oinion, death	occurred at the time	date and place	, and due to th	ne cause(s)
- > - 0		30. Name and address of person who co	mpleted cause of death stem	23а) (Туре		1858	1	APR	- 2	2007
	tate	31. Date filed (Month, Day, Year)	m/ey 90	Ure C	aton	HV	- 15al	to mov	e MD	4661
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, etc.	Physici		1. Decedent's Name (First, Middle, Last)			2007	3. Time of Death
	/Medic Examin	- 1	Eileen Bridget Mullan  4a. Facility Name (If not institution, give street and number)  4b.	o. City, Town, or Location of Death	March 13,	4c. County of Death	11:4JA
*:	*			Rockville Under 1 Year   If Under 24 Hrs.	1000 (000	Montgomery	y
3.	Funeral Director			onths Days Hours Min.	8. Date of Birth (Month, Day, Yea	1910 Ire	lace (State or Foreign try) Land
	pu s		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati	ion	,		0d. Inside City Limits
	Maryla f eho	tor	Maryland Montgomery Rockville			,	1 ☐ Yes 2 ☐ No
	ith the	Funeral Director		10f. Zip Code	10g. (	Citizen of What Coun	
	eath w	eral	7800 Potters Mill Court  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	20855		ited State	
9	after di or Item	Fun	Armed Forces? If Ye 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
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aryl	should and Men marke umatic	10	John Edward Deneng  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing A	Mary L Address (Street and Number or Rur	Murphy ral Route Number, City	y or Town, State, Zip	Code)
_	s 1 and 2 should f Health and Mer item 27 is marke other traumatic			otters Mill Ct.			0855
Baltimore,	Pages 1 ar		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition  Gate of Eigenstein Gat	aven Apri	L 2,	Location · City or To	
altin	# 분 <b>분</b> 증 .		4 □ Donation 5 □ Other (Specify) Cemetery  21. Signature → Funeral Service Licer See 22. No.	ame and Address of Facility Ro	obert A. P	wthorne, I umphrev Fi	meral Home
ä	Depa Impo eny ii		MOO803 Rock	cville, Inc. 30 cville, Maryland	O WestoMor	tgomery A	venue
*			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac	or respiratory arrest.		Approximate Interval Between Onset and Death
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	ted nsit	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			/	
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	death he atte ed for	Physician/Med	in the past 12 months?  1 Yes 2 14 Pregant at time of death 5 Ot	topic pregnancy ther (specify)		Month	Day Year
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E B					performed 1 ☐ Yes 2 ☐	death?	2□ No
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isio	after death. Director: After	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f. Location (Street	and Number or Rura	I Route Number
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	dicai (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death oc 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, igation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as si and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month.	Day, Year)
)	4		Meleg W. Karesh	1021726	ma	nch 14,	2007
	12		30. Name and address of person who completed cau = of death (Item 23a) (Type, Prince 2)	·	Colonia Principi		
P	Sta	te	31. Date filed (Month, Day, Year)  32 Registrar's Signature	loud, Denascus, 1		20072	
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			For State Registrar	State of Ma	aryland		artment of He <i>tificate of D</i>		Mental Hy	/gieno Reg. No	A M M -14	10013
		8	Decedent's Name (First, Middle, La	st)					2. Date of De	eath	<del></del>	3. Time of Death
	Physici /Medio		Nancy E. Maccli	ntock					March	21,	2007 Year	3:45 PM M
7	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or I	Location of Death		40		
			Montgomery Gene  5. Social Security Number 6.5				01ney	If Under 24 Hrs.	8. Date of Bi		Montgome	
15.	Funeral Director		,	ITM OFF	7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.						) Cou	place (State or Foreign Intry) entina
	/land ow at		10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
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	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 15322 Village L	ane			10f. Zip Code	20853		10g. Ci	tizen of What Cou	ntry?
36	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. 4 between 4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of His f Yes, specify Cuban ☐ Yes 2 No	panic Origin? (Sp., Mexican, Puerto	Decify Yes or No Decify Yes or No Decify Yes or No Decify Yes or No Decify Yes	0-	14. Race - Ameri Black, White, Specify:	, etc.
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215	within 72 ene. than "nat he Medic	Completed	(Specify only highest gr.	ide completed) College (1-4or 5-	+)	(Give life. [	kind of work done du OO NOT use retired)	iring most of worl	king			•
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an an	d be fill ental H ed oth	Be	17. Father's Name (First, Middle, Last Arthur Eberly	)			1	18. Mother's Nam	e (First, Middle	e, Maider	n Surname)	
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Baltimore,	. Pages tment of tant: If its jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🔀 Other (Specia	) in state				1				
ga	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Lice Ronald S.	Wade Dire	ctor	St Ba	Name and Address ate Anato 1timore, I	of Facility My Board MD 2120	1 655 W.	Bal	ltimore S	Street
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	Ing P	ü	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day	Year) 28	Bb. Time of Injury	28c. Injury a Work?		28d. Describe	how inju	ry occurred	
2	ttend death stor: / the f	cati	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		a. At homo	form atra		es 2 No	001 1			
2	al or A after al Dire d in by	Certification:	4 ☐ Homicide determined	28e. Place of injur building, etc.	(Specify)	, iaiii, stre	et, factory, office		City or To		nd Number or Rura e)	Il Houte Number,
:	in the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical C	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of hiner: On the basis of and manner state	examination	dge, death and/or inv	occurred at the time estigation, in my opin	, date and place, nion, death occur	and due to the red at the time,	cause(s date and	) and manner as s d place, and due to	tated. o the cause(s)
;	vithi To t	Ž	29b. Signature and title of certifier	my Dept	lead D	rector	29c. License n			29d. Da	te signed (Month,	Day, Year)
			30. Name and address of person who	completed cause of de-	ath (Itam 22	o) /Type E	rint)				1000	
	Sta	e	31. Date filed (Month, Day, Year)	32 Registrar	's Signature	rape	Philip Dr	1 Ome	MD	d	0532	
H	Registra		APR 0 2 2	107 January	J. J.	A	Philip Dr					

	4	For	State	of Mary	•	artment of I			al Hygie	ne		
		Registrar  1. Decedent's Name (First, Middle	( act)			ertificate of	Deam		Reg. te of Death	No. 2 0	17	3. Time of Death
Physician /Medica	1	ODES		ELSO	ON			Mo		Day 20	Year 2	7:50 / M
Examine	r	4a. Facility Name (If not institution			2	4b. City, Town, of		of Death  MD 3	1223	4c. County o	f Death	
Funeral Director		5. Social Security Number 214-64-8434	6. Sex 1 □ M 2 🖫 F	*	yrs. last birthday	- //	If Under	Min. (Mo	te of Birth onth, Day, Ye	947	9. Birthp Cour	place (State or Foreign atry) unk
pu »		Usual Residence of Decedent 10a. State 10b. County		110	c. City, Town or L	conting						
faryla shov		10a. State 10b. County		10	Balti						- [	0d. Inside City Limits 1
the M	20	10e. Street and Number			Daiti	10f. Zip Code			10a	Citizen of Wh	nat Cour	**
h with	2	1820 Spence St	reet GO1				1230		"		SA	,
Ifer death with the Mar r Items 23a or 28a-f sl ilner must be notified	2	11. Marital Status	12. Was De Armed F	cedent Ever	in U.S. 13	. Was Decedent of I	Hispanic Ori	igin? (Specify Ye	es or No-	14. Race		
urs after al"; or it	2	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced		2X No Bive		1 □ Yes 2 💟 No			,	Specify:		ack
72 ho	D C	15. Deceden (Specify only higher	t's Education	f)		edent's Usual Occu e kind of work done			nk 16b	. Kind of Bus	iness/In	dustry unk
within liene. r than "	combiered	Elementary/Secondary (0-12) unk		(1-4or 5+)	life.	DO NOT use retire	ed)					
be fill dot	0	17. Father's Name (First, Middle,	Last)		•	unk	18. Mothe	er's Name (First,	Middle, Maid	den Surname	)	unk
2 should and Me is mark	2 _	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mai	ling Address (Street	t and Numbe	er or Rural Route	e Number, Cit	ty or Town, S	tate, Zip	Code)
and 2 and 2 m 27 her tr	-	Bon Secours Hos	spital			W. Balti	more_					1223
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🎇 Other (S	3□Removal from	n State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ice)	Date	20c	. Location - C	ity or To	own, State
permit. Departr Importa any Inji		21. Signature of Eurieral Service Rona I d				Name and Address tate Anat altimore,		oard 65. 21201	5 W. B	altimo	re S	Street
Physician /Medical		23a. Part1. Let the disease, or shock, or ceart failure. List Immediate Caus. Final disease or condition resulting in death)	only one cause on	each line.		nter the mode of dyi	ng, such as	cardiac or respi	ratory arrest,			Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions	0 - 1	ENE	nsequence of):  ### NDXI	C EN	CEPH	3 W PA	THY			
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to		nsequence of):  DMUD	4813			,			
icate be executed physician and sthe burial-transit	Č	resulting in death) Last	c	(or as a co	nsequence of):	ABUSE	,					
ficate be physicial sthe bun	3		d	- •						_		
To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	yalcıdırını	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 🗆 gnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	ey			23d. Date Mont		ery Day Year
res that igned by be deta		Part II. Other significant condition			t resulting in the	underlying cause giv	ven in Part I.	. 23	e. Did tobacc	o use contrib	ute to th	ne cause of death?
aquires an signal by and by an and by an and by an and by an and by an and by an and by an and by an and by an and by an and by an and by an and by an and by an analysis of by analysis of by an analysis of by analysis of by analysis		GAERRAL	PALSY	,					1 ☐ Yes	2 □ No 3	☐ Prob	ably 4 Unknown
The law requi	ולם	DIABLES HYPERTER	MELLI	745				24	a. Was an autopsy	24b. We	ere auto	psy findings available appletion of cause of
hysician: The la	5 _	HYPER TEN	SIDN					1	performed Yes 2 <b>X</b>	? de	ath?	2 □ No
sician certifi rector	7	25. Was case referred to medical examiner?	Hospital:			Ott	ner:	of Death (Chec				
Phys er this eral dir	10	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient of Injury	2 ER/Outpatie	III 3 DOA	4 ∟ Nu	rsing Home 5		e 6 □Other		y)
ath. Tr. Affe		1 X Natural 5 ☐ Pending 2 ☐ Accident investig	9 1 '	nth, Day Ye	ar) Injury		rk? ]Yes 2 [∐l					
tal or Attending Frs after death.  al Director: After led in by the funer.		3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned Zoe. Plac	e of injury - ding, etc. <i>(S</i>		treet, factory, office		28f. Loc City	cation (Street y or Town, St	and Number	or Rura	I Route Number,
he Hospita n 24 hours he Funeral pletely filled		29a. Certifier 1 A Certifyin (Check only one) 1 Medical	Examiner: On the	ne best of my basis of exa nner stated.	y knowledge, dea mination and/or i	th occurred at the ti nvestigation, in my	ime, date an opinion, dea	nd place, and due ath occurred at th	e to the cause ne time, date	e(s) and mani and place, ar	ner as si	tated. the cause(s)
To the within To the comp		29b. Signature and title of certifier	10 . 0 . 1	Ola m	10	29c. Licens	0110			Date signed		
	-	30. Name and address of person  ANZT V. M.	who completed cau	use of death	(Item 23a) (Type	Print) John 4	). BA	Timone	87.6	103/2	mn	120 21222
State		31. Date filed (Month, Day, Year)	32.	Registrar's	Signature		_			··vijirij	112	1.10 01007

Registrar

APR 0 2 2007 Beach &

Theresa Parker 07-02300 UNKUNK

NK UNK		State of Maryland / Department of		lygiene	2007 1031
Physicia		1- For State Certificate of Registrar  1. Decedent's Name (First, Middle, Last)	Dealli	Re 2. Date of Deat	b 3. Time of Death
edical Exami				Month March 25,	Day Year 1745 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	n .	4c. County of Death
		1202 Tree Leaf Ct	Baltimore	lo para (p)	A Distriction (State of
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr: Months Days Hours Mir	_	th(MM/DD/YYYY) 9. Birthplace (State or Foreign
		Usual Residence of Decedent		Duy 10	e, 1967 Country)
any		10a. State 10b. County 10c. City, Town or Locat	ion		10d Inside City Limits
ind show nce.	5	MD Bal	timore.		1 Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?
0036 within 72 hours after death with the Maryland giene her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Ö	437 M'Aller Court	21202		USA
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	as Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
fler de		3 Widowed 4 Divorced If tes, Give tear 1	Yes 2 No specify:		Specify: Black
ours a	d by	15. Decedent's Education (Specify only highest grade completed)  16a Decedent during many	nt's Usual Occupation (Give kind of lost of working life. DO NOT use ref		16b. Kind of Business/Industry
6 n 72 h ian "n ical E	lete	Elementary/Secondary (0-12) College (1-4 or 5+)			
withingiene	Completed	17. Father's Name (First, Middle, Last)	Unemployed	e (First, Middle, M	(Inemplayed
21215-0036 build be filed within 7 Mental Hygiene marked other than ic event, the Medica	Be C	Franks Parker Sc	- Williams		
AD 21; 2 should b h and Men 27 is mar matic eve	To [	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing	g Address (Street and Number or	Rural Route Num	ober, City or Town, State, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene Itani: If them 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		Slyvia Johnson Mother 43'+	Mc Aller Corr	Date Date	11 more MD 21202- 20c. Location - City or Town, State
of Her		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:	sition (Name of cemetery, her place)		
altimore, rmit. Pages I a spartment of He sportant: If its		4 Donation 5 Other Specify: Clemater 21. Signature of Funeral Service Livensee 22.	Name d Address of Facility Q	02.2007	Baltimure, mD greene wind service
Baltimo permit. Page: Department o Important: injury or oth			728 Liberty na	and Born	greene twom salle
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter t	he mode of dying, such a cardiac	or respiratory arre	est, shock, or heart  Approximate Interval Between Onset and
/Medical Examiner	V. 7	failure. List only one cause on each line.  Immediate Cause (Final disease a Blunt Force Trauma to the Head a	nd Asphyxia		Death
Lammer		or condition resulting in death)  Due to (or as a consequence of):			
	ler	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death 1 ast events resulting in death 1 ast		_	
ecuted and transit					
e exe cian a	edical	UNPENDED X AMENDED PETFH, G866, 4/2/0	7 TT		
			etal death 3 Ectopic pregn	ancv	23d Date of delivery  Month Day Year
Sox 6876( leath certificate e attending phys	sician/M	past 12 months?  1 Live birth 2 Fe 4 Pregnant at time of death 5 0	ther (Specify)		,
Bo ne deat the at red for	Phys	1 Yes 2 No 9 V Unknown 9 Unknown	ded in the second of the second	220 Did to	bacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 6876.  Hospital or Attending Physician: The law requires that the death certificate 24 hours after death.  The neural Director: After this certificate has been signed by the attending phytety filled in by the funeral director, page 2 should be detached for use as the b	by F		underlying cause given in Part I.		s 2 No 3 Probably 4 Unknown
ds, equires een sig	sted		•	24a. Was	
COF	Completed				rmed? death?
tal Re tian: The certificate ector, page	S	25 Was case referred to medical	26 Place of Death (Check	1 Yes	2 No 1 Yes 2 No
of Vital Records, ng Physician: The law require Nher this certificate has been si nneral director, page 2 should b	o Be	examiner? Hospital: 1 Innation 3 EP/Outcation	Othor		Residence 6 🗸 Other: Scene
ing Phy After th	H	27 Manner of Death 280 Date of Injury 28h Time of	Injury 28c. Injury at Work?	28d. Describe I Subject ass	how injury occurred
ion ttendi leath. tor: / the fi	atio	1 Natural 5 Pending FOUND: Mar 25, 2007 1740 hrs	1 Yes 2 No		
Division tal or Attendiurs after death.  al Director: /	Certification:	3 Suicide 6 Could not be determined (Specify) Vacant Building	et, factory, office building, etc.	or Town, S	Street and Number or Rural Route Number, City State) af Court, Baltimore, MD
Di ospital hours a uneral I		Zya Centrer . The second secon	errad at the time, date and place, an	1	
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	ation, in my opinion, death occurred	at the time, date	and place, and due to the cause(s)
To To	₽	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
		SILLY I	O.C.M.E.		March 26, 2007
1		30. Name and address of person who completed cause of death (Item 23a)	on Street Baltimass MD 2	1201	
			nn Street, Baltimore, MD 2	1201	
S	tate	# 10 to 10 0 2007 678 5 10 4 678	W.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** a38 Kobert Duoley 03-29-07 "/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT 27 19 **Funeral** 1**X** M 2□ F Months 63 Days Hours 218 40 7903 Director mo Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits mo CARROLL SYKESVILLE 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be r BRINGE ROOM 4130 LONOON 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 XYes 2 No 1963-If Yes, Give Year or Dates: 1963 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ≥ Specify: 3 Widowed 4 Divorced WHITE Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ORBITAL Elementary/Secondary (0-12) College (1-4or 5+) QUALITY CONTROL ENG. Science 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PULLIN DUNLEY DOROTHY BASHAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Department of Health a Important: If item 27 is any injury or other trainonce. FRAN PULLIN 4130 LONDON BRIDGE ROUN SYKESVILLE MO 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 4/5/2007 OWINGS MILLS, MO GARRISON FORESTMUC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility N Zum B WN FH & MON CO 6028 SYKESVILLE ROAD ELDERS BURGIND 21784 23a. Part V Enter the disease of corr shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANOXIC ENCEPHALOPA THY Physician /Medical Due to (or as a consequence of): Examiner CARDIAC ARREST ASYSTOLIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) MYOCARDIAL INFARCTION ACUTE burial-tran and Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ RENAL DISEASE END-STAGE 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown Completed DIABSTES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 2 No or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after 24 hours a e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 2 2 29d. Date signed (Month, Day, Year) 3-29-07 D 3026 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 MEMORIAL AVENUE, WESTMINSTER, MD 2115-FRANCIS KHOO MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 2 2007

32 Registrar's Signature

		<ol> <li>State Registrar</li> <li>Decedent's Name (First, Middle, Las</li> </ol>	State of Maryla		tificate o			leg. No.	3. Time of De
Physic		Marie Violet Pi	nkard				Month	Day	Year
/Medi Exami		4a. Facility Name (If not institution, give			4b. City. Town	, or Location of De	March 3	0 • _2007 4c. County of	10:37 A
Exami	iici	9056 Meadowvale	,			ett City	aur		
Funeral		5. Social Security Number 6. Se	7. Age (In yr	s. last birthday)	If Under 1 Ye	ar If Under 24 H		Howar	
Director		219-54-6972	□M 2 <b>X</b> 0 F 94	Yrs.	Months Day	rs Hours Mi	n. (Month, Day August	, Year)	<ol> <li>Birthplace (State or F Country)</li> <li>Kentucky</li> </ol>
2		Usual Residence of Decedent					August	4, 1914	Kentucky
and Mental Hygiene.  and Mental Hygiene.  le markad other than "natural", or iteme 23e or 28e-f ehow aumatic event, tra Medical Examinar inaut be notified at	<u>_</u>	10a. State 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City I
al, or iteme 23a or 28a-f shot	Funeral Director	MD Howard	F	Ellicott	City				1 □ Yes 2∑
Ze Z	ä	10e. Street and Number			10f. Zip Code	•	1	0g. Citizen of W	hat Country?
23	rai	9056 Meadowvale			21042			United	States
e e	nue	11. Marital Status	12. Was Decedent Ever in Amed Forces?	U.S. 13. V	Vas Decedent o Yes, specify Ci	f Hispanic Origin? ( uban, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
0	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give	1	☐Yes 25th	o Specify:		Specify:	
2 4	pa	15. Decedent's Ed	Year or Dates:						
S S	Completed	(Specify only highest grad	de completed)	(Give I	ent's Usual Occ kind of work dor OO NOT use reti	e during most of w	orking	16b. Kind of Bus	iness/Industry
en en en en en en en en en en en en en e	E	Elementary/Secondary (0-12)	College (1-4or 5+)			•		D . 1	
ital Hygiene. id other than "nature event, the Madical		17. Father's Name (First, Middle, Last)		Dent	al Assi		ame (First, Middle, I	Dental	)
kad c	To Be	Ranson Forrest					orrest	naroon Surname	,
th and Men 7 te marke traumatic	-	19a. Informant's Name/Relationship (T	vpe. Print)	19h Mailing	Address /Stre		Rural Route Number	City or Town	4-4- 7:- O-4-1
5 ~ 5		Mary V. Cahill/da	•				Ellicot:		
item 27 other tr		20a. Method of Disposition		Place of Dispos					ity or Town, State
, <u>-</u> = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ I	TOTAL TION STATE			1			
문란증.		4 □ Donation 5 □ Other (Specify,  21. Signature of Funer II Service Lidens	011			tory 04/(	02/2007	Beltsvi	lle, MD
Depa Impo any I		3	1+++	'Ğ	Name and Add	me Cremat	ion Servi	ce P.O.	Box 784 ville, MD 2
		23a Parti Enter the disease or como	MO 12	21 B	everly	L. Heckro	tte. P.A.	Clarks	
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	ith. Do not ente	r the mode of a	ying, such as cardia	ac or respiratory arre	est,	Approximate Interval Betwee
nysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Debility						Onset and Dea
xaminer			Due to (or as a couse	quence of):					1
	<u>.</u>	Sequentially list conditions,	b. Due to (or as a conse	owers of					
nsit	Examiner	Sequentially list conditions, I say leading to min adiata cause. Enter Underlying Cause (Disease or injury	000101010000000000000000000000000000000	querios ory.					1
and al-tra	xar	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
r death. ector: After this certificete has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	ical E			1,					
phys s the	dic		3.						-
attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn	ancy				al l	
atter for L	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	al death 3 □E	ctopic pregnan Other (specify)	су		23d. Date	
ed by the atte	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown X	9☐ Unknown	oeatti 5 🗆 t	Other (specify)				,
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been s	ete								
has pe 2	E I						24a. Was an autopsy	24b. We	re autopsy findings ava or to completion of causi
certificete rector, pag							perform 1 Yes 2	ed: dea	ith? ]Yes 2□ No
ecto	Be	25. Was case referred to medical examiner?	lospital:				ath (Check only one	1	
al dir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2	ER/Outpatient	30 000		Home 5 ☐ Resider		
After funer	<u>6</u>	1 反 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe hor	w injury occurred	
death.	Certification;	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No			
Direction by	Ē	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stree ly)	et, factory, office		28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,
eral (			1						
Fun Fun tely f	ica	29a. Certifier 11 Certifying Physic (Check only 2 Medical Examin	sician: To the best of my kno ler: On the basis of examina and manner stated	owledge, death of the artion and/or inve	occurred at the t	ime, date and place	e, and due to the cau	use(s) and mann	er as stated.
within 24 hours efter death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	Medicai		and manner stated.						
		29b. Signature and title of certifier	Laur		29c. Licen	se number	29	d. Date signed (/	Month, Dey, Year)
¥ 1 8			, 0000		1 ()	70 70.	N	won 3	1 00/
¥ 1 8									
nO		30. Name and address of person who	mpleted cause of death (Item	n 23a) Type, Pr	rint)	1 1. (	+ TAILE	1/ /400	Wonth, Dey, Year)  21204

			1 - For State Registrar	State of Maryland		rtment of l			iene	10318
	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day Year	3. Time of Death
	/Medi Examin Funeral Director	cal	Ann Praniewski  4a Facility Name II not institution, give s  5. Social Security Number  214-24-9255	teath + Ko	ehal) ast binthday) Yrs.	4b. City, Town, If Under 1 Year Months Days		th	4c. County of Dea 4c. County of Dea ANNC 9. Bic 1919 Mar	Atunder  Athere  Athere  Athere
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	e Many	ctor	MD Anne Arun	nde1	Glen B	urnie				1 ☐ Yes 2 ☐ No
	with the a or 28	Director	10e. Street and Number 7355 Furnance Bran	ah Daad		10f. Zip Code	01060	10	g. Citizen of What C	ountry?
36	d within 72 hours after death with the Maryland jene. Ir than "natural", or Itema 23a or 28a-f show Itte Madical Exemirer must be notitled at	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2∑ No If Yes, Give	lf	as Decedent of I Yes, specify Cub		Specify Yes or No- to Rican, etc.)	USA  14. Race - Am Black, Whi	
Maryland 21215-0036	72 hours	ted t	15. Decedent's Educ	Year or Dates:	16a. Decede	nt's Usual Occu	pation		6b. Kind of Business	
121	within 7 ene. than "r	Completed	(Specify only highest grade	College (1-4or 5+)	life. Di	O NOT use retire		orking		
d 2	Hygid Other ent.	Be Co	unk unl 17. Father's Name (First, Middle, Last)	K	pharm	nacy tec		me (First, Middle, N	healthcar	e
ylan	2 should be and Mental Is marked of sumatic ever	To B	Louise Salamone				RAthe1	R. Mills	,	
Mar	nd 2 sho lith and 27 is m	l j	19a. Informant's Name/Relationship (Typ						City or Town, State,	Zip Code)
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		Lisa Yates/daught  20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	20b. Pla	ice of Disposi	h Stree tion (Name of atory or other pla		na MD 211 Date 2	L 2 2 Oc. Location - City or	Town, State
Balt	Dermit. Departr Imports any inji		21. Signature of Euneral Stryice Licenses	//lac	ва.	Ltimore,	MD 212	.01	Baltimore	Street
	Fnysician :	8 9	23a. Palt 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or a ndition resulting in de it.)	cause on each line.	Do not enter	the mode of dyir	ng, such as cardia	c or respiratory arre		Approximate Interval Between Onset and Death
8760,	Medical Examiner  bhysician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseque	RBC*	TOL	FISTUL	-A ·		
P.O. Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3□E	ctopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	w requires that been signed b should be dete	Ď	Part II. Other significant conditions control CONGESTIVE	- HEART	FAIL	ure			acco use contribute to	the cause of death?
al Records,		Completed	CITRONIC OF	SAMUCIVE	LU	NG DIS	FASE	24a. Was an autopsy perform	24b. Were au prior to death?	utopsy findings available completion of cause of
Vital	ysicien: Th is certificate director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐ EF		3CI DOA Oth		ath (Check only one	ce 6 □Other (Spe	
Division of	ding Ph J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		8b. Time of Injury	28c. Injun Wor	y at k? Yes 2 □ No	28d. Describe how		cny)
DIX	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hombuilding, etc. (Specify)				City or Town,	·	
	To the Hospitel within 24 hours of To the Funeral completely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my knowled to the basis of examination and manner stated.	edge, death o n and/or inves	ccurred at the tin stigation, in my o	ne, date and place pinion, death occu	, and due to the cat rred at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the compl.		29b. Signature and title of cartifier			29c. Licensi	e number	290	d. Date signed (Mont)	h. Day, Year)
			> Ky) Lunu	en mo			7753		3-26-	07
				ASONA, MU	0.3	721 Pa	STEE S	. BALS	MONE, u	40 2/225 1
	Stat Registra	.6	31. Date filed (Month, Day, Year)  ADD 0 9 2007	32. Registrar's Signatur	Last	0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9866 4-2-07 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No, 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03-30-2007 LOUISE ROSS 1:58 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Bh (Month, Day, Year)
JUNE 45 1928 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours Country) Director 216-20-7604 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD BALTIMORE 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 1027 CATHEDRAL STREET Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Completed by Specify. BLACK 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ JAMES MITCHELL ODESSA MILES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA CORNISH-SCOTT/DAUGHTER 1232 WALTERS AVENUE, BALTIMORE, MD 21239 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Purial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL 4/5/2007 BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC Signature of Funeral Service Licenses () 1701 LAURENS ST., BALTO., MD 21217 23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Diabetic ONROPAT jews disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cunsiquence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 State (Specify) Work W 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

Agron

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Day, Year) March 30 2007

			For State Registrar		State o	of Mar	-		rtment of F			lental H	ygier Reg. N	1	7	10	320
100	Physici	an	1. Decedent's Name (First,	Middle, Las	t)			, .				2. Date of D	eath		Year	3. Time o	of Death
N. S.	/Medic	al	LydiA  4a. Facility Name (If not inst	itution civo	otmot and nu	mhor)	K	IV	CRA	e Longine	of Dooth	APRII	1	, 200	)7	8:09	<u>A</u> M
	Examin	er	GREATER BAL	_			4b. City, Town, or Location of De CENTER TOWSON					h 4c. County of Death BALTIMORE					
- Marie - Mari	Funeral		5. Social Security Number	6. Se			In yrs. last birt		If Under 1 Year Months Days	If Unde	er 24 Hrs. Min.	8. Date of B	irth ay, Yea	ır)	9. Birth	place (State ntry)	0 '
(day 50)	Director		062-30-3308 Usual Residence of Decede			_	90	Yrs.				April	2,1	926	tu	erto	RICO
ryland	how	_	10a. State 10b. Co	ounty		10	0c. City, Town									10d. Inside (	
the Ms	28a-f	Director	MARYIAND  10e. Street and Number				DA	1+1	MOCC 10f. Zip Code				100 (	Oltizen of Wh			s 2∏No
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er deat	tems a	Funeral	11. Marital Status		12. Was Dec	edent Eve orces?	er in U.S.	13. V	as Decedent of H	lispanic O an, Mexic	rigin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	0-		- Americ	can Indian,	
)36 Jrs affe	al", or i	by	1 ☐ Never Married 2 ☐ Never Married 2 ☐ Dive		1 ∐Yes If Yes, Gi Year or D	ve		1	Yes 2□No	Specify	P	L Ric	HA	Specify:		iite	
- γ <i>d έ</i> α :1215-0036 within 72 hours after death with the Marvland	'natura dical E	Completed	15. Dec (Specify only i	edent's Edu nighest grad			16a.	Decea	ent's Usual Occup	ation			16b.	Kind of Bus	iness/In	dustry	
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Ind 2	other vent, t	Be C	17. Father's Name (First, Mi	ddle, Last)		T)	l		croty	18. Moth	ner's Nam	e (First, Middl	e, Maide			1	
era, Lydia Maryland 21215-0036	l Ment narked natic e	일	Leoncio			_ ^_	JCELA					COLIN				itre	*
V & Mai	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Rela			HUSBI	19b.	Mailing OS	Address (Street	and Numi	ber or Rur	al Route Num الملك	ber, City	or Town, S	tate, Zip	Code)	ウェフル
altimore,	of Hear fitem rothe		20a. Method of Disposition 1 A Burial 2 ☐ Crema			0	cemeter	v, crem	ition (ivarne of atory or other plac	ce)	1	Jate	20c.	Location - C	ity or To	own, State	
time to Pag	tment tant: I		4 ☐ Donation 5 ☐ Oth	er (Specify,	)	State	CALVA	24 (	EMETER	y	April	5,2007	Wa	POPSIL	E	NY	<i>'</i>
Balti permit.	Depar Impor any Ir once,		21. Signature of Funeral Se	rvice tricens	see •	-	_	22.	EMETER Name and Addre OSEPL N	ss of Faci	ANA	INO =	Tr.	Fund + Ba	CRA	4/10	ue
	Sept. 4		23a. Part1 Enter the disease shock, or heart failure.	e, of comp	lications that cone cause on e	aused the	e death. Do n	ot ente	r the mode of dyir	ng, such a	s cardiac	or respiratory	arrest,	I On	110	Approxima Interval Be	ite otwoon
	nysician		Immediate Cause (Final disease or condition resulting in death)			sep										Onset and	Death
	Medical xaminer		resulting in death)		Due to		onsequence o	,	101								
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it the d	ed by the detached	hysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown		9□Unkno		le or death	2	Other (specify)								
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Division or Vital Records, P.O. Box 68760,	page 2	Completed by Physician/Me										24a. Was auto perf 1⊟ Yes		pri de:	ere auto or to co ath? ]Yes	psy findings mpletion of c	available cause of
Vita ician:	sertifi	Be	25. Was case referred to me examiner?	-	Jacobsky						e of Death	(Check only			7163	27,010	
Or Phys	this dir	은	1 ☐ Yes 2 ☐ No 27. Manuer of Death	1	28a. Date of	npatient of Injury	2 ER/Outp		3 DOA Othe	4 LJ N		me 5□Res 28d. Describe				y)	
ion	ath. 7r: Afte ne fune	atior	Z III Modiaciii	estigation/	(Mont	h, Day Ye	ear) In	jury		k? Yes 2 ⊑		-54. 25001100	,,,,,	ary coourre	•		
Division or Vital Records, P.O	within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fur	Certification:		ould not be termined	28e. Place buildir	of injury - ng, etc. (S	At home, farr Specify)	n, stree	et, factory, office			28f. Location ( City or To	Street a wn, Sta	and Number te)	or Rura	l Route Nur	nber,
To the Hospital	hours uneral	ا <u>تع</u>	29a. Certifier 1 Cer	tifying Phy	sician: To the	best of m	ıy knowledge,	death	occurred at the tin	ne, date a	nd place,	and due to the	cause(	s) and manr	ner as s	tated.	
the H	thin 24 the Fi	Medical	one)		and manr	ner stated	amination and	or inve	estigation, in my o		ath occur	ed at the time					s)
۴	<b>7</b> W		29b. Signature and title of ce		and	M	0		29c. License		47		29d. D	ate signed (			
	8		30. Name and address of pe		ompleted cause		(Item 23a) (T	ype, P	int) Char	les	5+	BAIT	in	01e	MI	1212	04
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	Registra	ar	APR 0	2007	Section	40.	I A	284	U .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROBINSON Month **Physician** PATRICIA MARCH 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bon Secours Hospital Baltimore City 9. Birthplace (State or Foreign Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M Country 212-46-2563 61 Director 11/30/1945 AZ Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehromany injury or other traumatic event. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 □ No Funeral Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1405 Dukeland Street

1 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: Never Married 2 Married 20 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 Divorced Rlack Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Library Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles H. Robinson Marjorie Hudson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Robinson/Mother 1405 Dukeland Street Baltimore, MD 21216
of Disposition (Name of Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 2 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2007 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives Du M01443 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the more of ying, such as carniac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland 21286 Interval Between Onset and Death CORONARY ATHEROSCLEROSIS Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner that the death certificate be executed physician and is the burial-trans resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 es 2 No 1 🔲 Inpatient 2 R/Outpatient 3 DOA 2 To the HospItal or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral ( Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 W Paltinge OL 31. Date filed (Month, Day,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU / 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Louis Rubin 2007 March 1:15P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 7111 45th Street Chevy Chase
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min <u>Montgomery</u> 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours XXM 2□F 89 Director 578**-**05**-**0971 1918 Michigan 10, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23s or 28s-f ehow the Medical Examinar must be notified at 1X Yes 2 □ No Directo Maryland| Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7111 45th Street 20815 Completed by Funeral <u>United States</u> filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 □ No World
If Yes, Give
Year or Dates: War I Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced War II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Framing & Art Supply ith and Mental Hygie 27 is marked other r traumetic event, permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If them 27 is marked other any injury or other traumation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Rubin Sara Brott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Baron Rubin/Wife 7111 45th Street, Chevy Chase, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place)

Mt. Lebanon 20a. Method of Disposition Date 20c. Location - City or Town, State Mt. Leva... Cemetery March 30, 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Luneral Service Ligensee MO0803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Failure to Thrive Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 🗌 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient 2 Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural death Il Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40051280 3-19-2007 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print) Anushiravan Dadgar, D.O. 9715 Medical Center Drive, #201, Rockville, MD State Registrar

			For State Registrar	State of	Maryland /		artment ( rtificate			Mental H	ygiene Reg. Na	and the last term	10000	
	Physic	ian	Decedent's Name (First, Midd	lle, Last)			<del></del>	*		2. Date of I	Death Da	ay Year		
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	yland now at		10a. State 10b. County	У	10c. City, Tov	wn or Lo	cation						10d. Inside City Limits	
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anc	nould be f f Mental h narked of	Be	, ,	,				10	s. Mother's Na	me (First, Middi		,		
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ŏ	that the death certified by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me pf pregnancy							23d. Date of de	elivery	
P.C. Box	death a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pregnan	n 2□Fetal deat t at time of death		]Ectopic pregr ] Other <i>(speci</i> i					Month	Day Year	
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Ţ	ned be deta	by P	Part II. Other significant conditi	ons contributing to deat	h but not resulting i	in the ur	nderlying caus	e given i	n Part I.	23e. Did	tobacco	use contribute t	o the cause of death?	
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ပ္ပ	The law requires that the death certifite has been signed by the attending age 2 should be detached for use as	Completed	Alzheimer's	Disease						24a, Wa	s an	24b. Were a	utopsy findings available	
Ĕ	The lav	ᄨ								auto	opsy formed?	prior to death?	completion of cause of	
			25. Was case referred to medica	ul l				26	S Place of Do	1□ Yes ath (Check only		1 ∐Yes	s 2 □ No	
5	ysici s cer direct	To Be	examiner? 1 ☐ Yes 2 ሺ No	Hospital: 1 ☐ Inpa	atient 2 ER/O	utpatien	t 3 DOA	Othor		Home 5∭ Res		€ □Other (Cre		
Division or Vital Records,	g Ph er thi eral (	اۃا	27. Manner of Death	28a. Date of I	njury 28b.	Time of		Injury at Work?		28d. Describe			эспу)	
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2	Atter dea ector	<u>≅</u>	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined   28e. Place of	injury - At home, fa	arm, stre	eet, factory, of	flice		28f. Location	(Street ar	nd Number or R	ural Route Number,	
5	al or s afte al Dir	Certification:	4 [] Hornicide	building,	etc. (Specify)					City or To	own, State	e)		
	To the Hospital or Attending Physician: whithin 24 hours after death. To the Funeral Director: After this certification between the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director of the funeral director.	Medical (	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner	s of examination a	je, death nd/or inv	occurred at t restigation, in	he time, my opini	date and place on, death occ	e, and due to the urred at the time	e cause(s e, date an	) and manner a d place, and du	s stated. e to the cause(s)	
	To th withir To th Somp	Me	29b. Signature and title of certifie	Delle			29c. Li	cense nu	ımber		29d. Da	te signed (Moni	th, Day, Year)	
	<		2	20057834					3/29/2001					
١	0	}	30. Name and address of person	who completed cause o	f death (Item 23a)	(Type, F	Print)							
	0		Damion Doyle,				,	eet,	Rockv	ille, Ma	ary1a	and 2085	50	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	_								
	Registr	ar	APR 0 2. 2	007 Been	, B. A.	2004	W.							
DH	#H 17 Rev 1/2	201	MIN V & C	1	17	-				-				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Veal THOMAS 08:59 AM SMITH MARCH 29,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death VORTHUEST HOSPITAL SALTMORE 12ANMILLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director Moryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 □ No Director ltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 3114 Phheims SA . Race - American Indian, Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: Blach

16b. Kind of Business/Industry þ 3 ☐ Widowed 4 ☐ Divorced or than "natura the Medical E Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Docial 10013 aims Examines 7 is marked other traumatic event, t Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith ဥ -li2abeth Clayborne 19a. Informarit's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai once. Pheims Boad Baltimore mo 21240 Alvis M. Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 22. Hame and Address of Facility Vough C. Green Jurial Server 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bood Mandallotan mo Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERY DISEASE CORONARY /Medical Due to (or as a consequence of): HIGH BLOOD Examiner DRESSURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties of 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2∐No Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ■ ER/Outpatient 3 □ DOA ဂ 1 Inpatient this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0061579 M. O. 79, 200 t 10

State Registrar

MARK

31. Date filed (Month, Day, Year)

GOUDSTEIN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

DATHWEST

MOSPITAL

KANDALLS TOWN, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SMITH SHANNON 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MERCY BALTIMORE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 220866779 Director Usuat Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 is marked other then "naturel", or iteme 23s or 28e-f show ury or other treumatic event, the Medical Examinations and item and the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMENE CITY Director BALTIMORE Ŷes 2□No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code HINSDALE 2816 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: BLACK Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced ear or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) UNEMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. 20b. Place of Disposition (Name of Annapolis, MD 21403 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or 4 ☐ Donation 5 ☐ Other (Specify) emoteru 21. Signal re of Fune a Servi VICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) ACQUIRED IMMUNOPEFICIENCY SYNDROME Enysician /Medical Examiner IMMUNODEFICIERCY HUMAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, ettending physicien for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes No
9 ☐ Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ , page 2 should be 3 Probably 4 □Unknown Be Completed 1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No After this certific funerel director, 25. Was case referred to medical 26. Place of Death | Check only one Hospitat: Inpatient 1□Yes 2XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

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			For State Registrar	State of Mary		epartment of F		-	giene Reg. No. (	0007	10226
	Physic	ian	Decedent's Name (First, Middle, Las	st)			Journ	2. Date of De		Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give	- I M D		4h City Town o	r Location of Death	March	30	2007 ounty of Death	- 1005 PM
	Examir	ner	University a Mar	yland Me	dical Ce	ster B	al times	1	N/A	•	
	Funeral Director		5. Social Security Number 6. S 212-10-3397  Usual Residence of Decedent	ek 7. Age (1. ☐ M 2 X F	n yrs. last birth	Months Days	If Under 24 Hrs. Hours Min,	8. Date of Bir (Month, Da 06/07/		9. Birth	place (State or Foreign Intry) /land
	yland how at		10a. State 10b. County	10	Oc. City, Town	or Location					10d. Inside City Limits
	ne Mar 8a-f sl etifled	Director	MD Harford		Bel Air	•					1 ☐ Yes 2 ☑ No
	with the		10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cou	intry?
	death	Funeral	1405 Hardley Cour	12. Was Decedent Eve Armed Forces?	er in U.S.	21014  13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe	cify Yes or No	U.S.A.	Race - Ameri	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:	Hican, etc.)		Black, White pecify: Wh	ite
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pu	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)			ircar secre	18. Mother's Name	(First, Middle,			
ylaı	nould be I Mental narked c	은	Waclaw Nitkoski				Eva Hartk				
⊠a	and 2 should saith and Men n 27 is marke er traumatic		19a. Informant's Name/Relationship (1)  James E. Schiaffi			Mailing Address (Street a					p Code)
Ē,	s 1 and 2 of Health Item 27 other tra		20a. Method of Disposition	1	20b. Place of D	05 Hardley Disposition (Name of crematory or other place	; D	Alr,	MD 21 20c. Locati	O14 ion - City or T	own, State
Ë	Pages ment of I ant: If Ite		1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Specify</i>		•	nislaus Cen	í i	3/2007	Baltin	more. N	Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen			22. Name and Addres	ss of Facility	eonard	J. Ru	ck, In	С.
17			23a. Part1. Enter the disease, or comp	lightions that caused the	e death. Do no	5305 Harfo	rd Rd. Ba g. such as cardiac o	1timore	e, Mar	vland_	21214 Approximate
	Physician		shock, or heart failure. List only to Immediate Cause (Final disease or condition	one cause on each line.	J	1 11 more	6 C 4	r roopiiatory ai	.,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or as a co	onsequence of	TI CANTALA	Carjo				days
	LAdillilei	P.	Sequentially list conditions,	b	arsectie non off	,				_	
	uted d ansit	Examiner	Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0	or recognition on						
b.	cate be executed physician and the burial-transit	ШX	resulting in death) Last	Due to (or as a co	onsequence of)	:		**			-
38760,	icate b physic the b	dical		d							
Box (	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p	pregnancy				23d	. Date of deliv	env
	at the death by the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			200.	Month	Day Year
Division or Vital Records, P.O	The law requires that the death certificate has been signed by the attending I hage 2 should be detached for use as	by	Part II. Other significant conditions of	entributing to death but no	ot resulting in th	ne underlying cause give	en in Part I.		obacco use d		he cause of death?
eco	law rec as bee 2 shou	Completed			_			24a. Was		4b. Were auto	ppsy findings available
E H	<b>sician:</b> The law certificate has t irector, page 2 s	Com						autop perfo 1∐ Yes	rmed2. 2 X No	death? 1 ☐ Yes	mpletion of cause of 2000 No
VIII	lysician: iis certific director,	00	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient	2000	ationt 3 DOA Othe	26. Place of Death				
יס ר	ig Physter this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tin	ne of 28c. Injury	4 Indursing Hon	ne 5 ☐ Resid 8d. Describe h			(y)
sior	tendin eath. tor: Af the fur	catio	1 Natural 5 ☐ Pending 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 1	Yes 2 □ No				
Divi	l or At after d Direct I in by	Certification:	4 Homicide determined	28e. Place of injury - building, etc. (S	At home, farm Specify)	, street, factory, office	2	8f. Location (S City or Tow	Street and Ni vn, State)	umber or Run	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	vsician: To the best of m iner: On the basis of exa and manner stated.	amination and/i	leath occurred at the timer investigation, in my op	ne, date and place, a pinion, death occurre	and due to the ead at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)
_	To the within To the complete	Me	29b. Signature and the of certifier			29c. License	number		29d. Date si	gned (Month,	Day, Year)
			1/1/	J MD		1251	2		Marr.	h 31.	2007
	8		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Ty	pe, Print)	Str. +	D. 1	1	,,	2007
	Sta	te	31. Date filed (Month, Day, Year)	32. giştrar's	Signature	- Druke	street	Dal	nmore	MI	) 21201
	Registr		APR 0 2 2	307 Degue	· K	gracke?					

			1 - For State Registrar	State o	f Marylar		artmen rtificat			and M		giene Reg. No.2 () (	) 7	10327
ĺ	Physici /Medio		1. Decedent's Name (First, Middle, Anna Maude Stull								2. Date of De. Month March 2		Year	3. Time of Death 17:53 M
	Examir		4a. Facility Name (If not institution, of Montgomery General				4b. City,		Location o	ol Death		4c. County of		7
	Funeral Director		174-12-6714	.Sex 1□M 2፟ဩF	7. Age (In yrs.		If Under Months		II Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jan. 1	v Year)	Cou	place (State or Foreign http) 1Sylvania
	Maryland -f ehow	for	Usual Residence of Decedent  10a. State  10b. County  Maryland Montgor	ner∨		ity, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28e	ai Direc	10e. Street and Number 3618 Gleneagles				10f. Zip	Code 906				10g. Citizen of W United S		-
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28e-f ehow other treumatic event, the Madical Examinal must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec Armed Fo	edent Ever in U prces? 2区No ve	1	Was Deced If Yes, spec		ispanic Orig an, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	- 14. Race Black Specify:	- Americ , White, Wh:	
21215-0036	a within 72 ho plene. r then "natur the Medical.	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		1-4or 5+)	16a. Dece (Give life. Homema	kind of wo DO NOT u	al Occup irk done d se retired	ation during most f)	t of workii	ng	16b. Kind of Bus		dustry
Maryland 2	should be filed nd Mentat Hygid marked other umatic event, it	To Be C	17. Father's Name (First, Middle, La Charles F. Stub	ole				(0)	Bert	ĥa N	. Brenn			0.41
	ages 1 and 2 sh nt of Heelth and t: ff Item 27 is n / or other treum		19a. Informant's Name/Relationship Edward L. Stull 20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3	/ Son	State	20600 Place of Dispo cemetery, crer	Geo esition (Name that only or o	rgia ne of other plac	Ave.	, Br Apri	ookevil	ne, City or Town, S.  le, Mary  20c. Location - C	land	d 20833 own, State
Baltimore,	permit. Pages : Depertment of H Important: if ite eny injury or ot once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Control of Service Control			ntgomery Rö 96 30	Name an	d Addres	ss of Facility	y Funer	al Home/	Bethesda Rockville, ckville,	Inc	
760,	Physician // // // // // // // // // // // // //	ilcai Examiner	23a. Pan1. Enter the disease, or or shock, or hear failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 a.y. Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	oach line.  Cor as a conservation as a conservat	Quence of):  VM Of	nia tu	P21	rty			Ma		Approximate Interval Between Onset and Death
.O. Box 68	The law requires thet the death certifica sie hes been signed by the ettending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		ointh 2 ☐ Feta nantat time of	al death 3	Ectopic pr		21162			23d. Date Mont		ery Day Year
<u>α</u>	w requires thet been signed by should be deta	۵	Part II. Other significant condition  Rubde	s contributing to d	eath but not re	sulting in the u	nderlying c	ause givi	en in Part I.		1		_	he cause of death?
Vital Records,		Completed	Acuk	rend	<u>l</u> 1	eci/c	M	2				pr rmed? pr	or to co	ppsy findings available mpletion of cause of 2 No
	sicien: Th s certificete lirector, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	TER/Outnation	at all no	Oth	er		Check only o	ine) dence 6 ⊡Othe	(Special	6c)
Division of	To the Hospital or Attending Physicien: within 24 hours elfer death within 25 cours of the Funeral Director. After this certification properties in by the funeral director, completely filled in by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		28c. Injun Worl		2		now injury occurre		<b>y</b> )
Divis	o the Hospital or Attend ithin 24 hours effer death to the Funeral Director: ompletely filled in by the	Certification:	3 Suicide 6 Could no determina	288. Place	of Injury - At h ing, etc. (Speci	nome, farm, str	eet, factory	y, office		2	281. Location (5 City or Tov	Street and Numbe vn, State)	r or Rura	al Route Number,
	To the Hospital or within 24 hours efte To the Funeral Directional Direction of the Funeral Dire	edical	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical Exone)	aminer: On the b	best of my knasis of examination stated.	owledge, death ation and/or in	occurred vestigation	at the tin , in my of	ne, date and pinion, deat	d place, a th occurre	and due to the ed at the time,	cause(s) and man date and place, ar	ner as s nd due t	stated. o the cause(s)
)	To To to to to to to to to to to to to to to	Σ	29b. Signature and title of certifier	-e			290	License U	o number	P		29d. Date signed 3/27	(Month,	Day, Year)
į'	) .		30. Name and address of person with	o completed caus	se of death (Ite	m 23a) (Type,	Print)		8101 lney,			lip Drive 20832		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 2		legistrar's Sign	ature	ants)							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Muriel S. Shoemaker March 28, 2007 $10:40P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brighton Gardens Montgomery Rockville 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Hours 1 ☐ M 2**X** F Days Min. 91 Director 158-10-1591 Oct. 1, 1915 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits Director 1 TYes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9200 Adelaide Court by Funeral 20817 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or itel other traumatic event, the Medical Examine Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Midowed 4 □ Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Winifred Siddons 2 Edmund Reeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jill S. Seal/Daughter</u> 9200 Adelaide Court, Bethesda, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery permit. Pages 1 Department of H Important: If ite any injury or ot 20c. Location - City or Town, State March 29, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 200/ 22. Name and Address of Facility, Robert A. Bethesda-Chevy Chase, Inc. Bethesda Maryland 20814-4 ☐ Donation 5 ☐ Other (Specify) NOT Bethesda, Maryland Robert A. Tumphrey Funeral Home hase, Inc. 7557 Wisconsin Avenue and 20814-3501 21. Signal of Funeral Service Licensee M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last July to (or as a surresquence of): Examine Hypertension Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 Tes 2 No 3 Probably 4 Unknown Dysphagia 24b. Were autopsy findings available prior to completion of cause of death? No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

**Physician** /Medical Examiner that the death certificate be executed

death

Baltimore, Maryland 21215-0036

physician and s the burial-tran attending p as been signed by the 2 should be detached has page certificate

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

Be 2 within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification:

						autopsy performed? 1□ Yes 2⊡No	prior to comp death? 1 ☐ Yes 2
				26. Place of D	eath (C	Check only one)	
Ho	ospital: 1 Inpatient 2	]ER/Outpatient	3 🗆 DO	Other: 4 Nursing	Home	5 ☐ Residence	6 □Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	Bc. Injury at Work?		I. Describe how inju	

1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

March 29, 2007

(Check only one) and manner stated. 29b. Signature and title of

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajay Reddy, MLD. 6320 Democracy Boulevard, Bethesda, Maryland 20817 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

2007



			ricasc		d/Danatalible ink. En	•	•
			1 _ State	State of Marylan	d / Department of Health		2007 10220
			Registrar  1. Decedent's Name (First, Middle, Li	ist)	Certificate of Deal	2. Date of Death	. N6 UU / 1 U J & J
	Physic /Medi	cal	Ernest Stephen			Mar	Day Year 9.50 PM
4	Exami	ner	4a. Facility Name (If not institution, gir	e street and number)	4b. City, Town, or Location	on of Death	4c. County of Death
	Funeral	-	5. Social Security Number 6.	Sex 7. Age (In yrs. It		der 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		226-24-6473 Usual Residence of Decedent	1X M 2□F 83	Yrs. Months Days Hour	s Min. (Month, Day, Y	1923 Maryland
	show	_	10a. State 10b. County		, Town or Location		10d. Inside City Limits
	h the Marylar r 28a-f show	cto	MD Anne Aru	ndel	Glen Burnie		1 ☐ Yes 21∏ No
	§ 23	al Director	10e. Street and Number 7355 Furnace Bra	nch Road	10f. Zip Code 210		Citizen of What Country?
	dea dea	Funerai	11. Marital Status unk	12. Was Decedent Ever in U.S Armed Forces?			14. Race - American Indian,
36	hours after tural', or ite	y Fu	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2 ☒ No Speci		Black, White, etc.  Specify: black
Ö	72 hours 'natural',	ed by	3 Widowed 4 Divorced	Year or Dates:			
15	C . 3	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)	ost of working unk 16	b. Kind of Business/Industry unk
212	filed within 7 I Hygiene. other than "rent, in Mar	mo	Elementary/Secondary (0-12) unk u	College (1-4or 5+) nk			
Maryland 21215-0036	be filed stal Hygi ed other	Bec	17. Father's Name (First, Middle, Last	)	unk 18. Mo	ther's Name (First, Middle, Mai	den Sumame) unk
yla	should be nd Menta marked imatic ev	2					4.
Mai	S es as	7 1	19a. Informant's Name/Relationship		19b. Mailing Address (Street and Nun		
	s 1 and of Health item 27 other tr	ll a	Mariner of Glen I  20a. Method of Disposition	20b. Pl	7355 Furnace Bran		urnie, MD 21060
lo E	ages ant of it: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special	Removal from State	metery, crematory or other place)	200	. Location - Oily of Town, State
Baltimore,	permit. Pages Depertment of I Important: If its any injury or o		21. Signature of Funeral Service Lice Ronald S		22. Name and Address of Fac	cility	
ä	Deporting Suny in Suny		Ronald S.	Wade, Director	State Anatomy Baltimore, MD	Board 655 W. 21201	Baltimore Street
	(#T-11111		23a. Part1. En er the disease, ir com shock, or hart failure. List only	nlications that caused the death.	Do not enter the mode of dying, such		Approximate
	Physician		Immediate Caus (Final disease or condition	CARCINI	OMA OF	PANCRE	A C Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as a consequ			371010717
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	per tiss	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):		
	ate be executed nysician and he burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):		
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89	lificati g phy as the			u.			
Вох	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan			23d. Date of delivery
4	deat deatt	sicie	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of dea			Month Day Year
P.0	at the 1 by th stach	Phys	9 🗆 Unknown				
s,	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	by	Part II. Other significant conditions of	ontributing to death but not resul	ting in the underlying cause given in Par		co use contribute to the cause of death?
orc	w requir been si should I	eted				1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	e 2 si	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
alF						performed 1 ☐ Yes 2 🗗	? death? No 1 Yes 2 No
Vital	Physicien: this certificatal director,	o Be	25. Was case referred to medical examiner?	Hospital:	Other *	ce of Death (Check only one)	
of	Phy this	는 눈	1 Yes 2 Yo	1 Unpatient 2 UE	P/Outpatient 3 DOA Carer: 402	ursing Home 5 Residence 28d. Describe how in	
ion	nding Ph lth. : After th s funeral	ig l	1 ✓ latural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury Work? M 1 ☐ Yes 2 [		nary occurred
Division	I or Attsndi after death. Director: A I in by the fu	iffice	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At non	ne, farm, street, factory, office	28f. Location (Street	and Number or Rural Route Number,
Ö	s afte	Certification:	4   Homicide	building, etc. (Specily)		City or Town, St	'ate)
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	ledge, death occurred at the time, date a on and/or investigation, in my opinion, de	and place, and due to the cause	e(s) and manner as stated.
	the H the F the F	Medicai	- ti	and manner stated.			
	To To	-	29b. Signature and title of certifier	59/	29c. Ureense number	1160	Date signed (Month, Day, Year)
		-	(1)	0 10		LICO PIN	17/2/2001
			30. Name and address of person who	completed cause of death (Item	San (Type Print) A RITC	HIEHIGHV	JAY BALTIMORA
	Sta	e	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	MAKE	TLAND -	21225
	Registr		APR 0 2 200		Sparle		

		1 - For Amend #29c,30, Registrar		66, 4/2/07 1	ertificate o	f Death		Heg. No.	IJ/	10336
Physici	an	Decedent's Name (First, Middle, Last)					2. Date of D Month	eath 27, 200	Year	3. Time of Death
/Medio		Joyce E. Simmons								11:58 AM
Examir	ier	4a. Facility Neme (If not institution, give Garrett County Me			4b. City, Town	n, or Location of $\operatorname{\sf nd}$	Death	Garr	y of Death ett	
Funeral Director		234-44-0037	7. A	nge (In yrs. last birtho 74 Yrs	Months Day		Min. 8. Date of Bi (Month, D Apr 29	ay, Year)	9. Birthpla Countr Mary	
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음	ō	MD Oakland		Ga	rrett					1 ☐ Yes 2√∑N
28a-	Funeral Director	10e. Street and Number			10f. Zip Code	9		10g. Citizen of	What Countr	v?
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10 Z	era		12. Was Deceden	it Ever in U.S.	13. Was Decedent of	21550 of Hispanic Orig	in? (Specify Yes or N	o- 14. Ra	USA Ice - America	
l', or iter zaminer	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	No	If Yes, specify C 1 ☐ Yes 2X		Puèrto Rican, etc.)	Speci	ack, White, et ify: whi	
atura B E	ed	15. Decedent's Edu		16a. D	ecedent's Usual Occ			16b. Kind of E	Business/Indu	istry
L H	Completed	(Specify only highest grad	e completed) College (1-4o	- Ji	Rive kind of work do Te. DO NOT use ret	ne during most ired)	of working			ŕ
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othe ent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle			
denta rked tlc e	To	Arthur William (	ulp			Pea	rl Victori	a Hartm	an	
8 me		19a. Informant's Name/Relationship (T)			lailing Address (Stre		or Rural Route Numi			Code)
27 I		Elizabeth Weasefo	rth/daug	thter P.	O. Box 74	Burlin	gton, WV	26710		
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anote.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☒ Donation 5 ☐ Other (Specify)	lemoval from Stat	camatan/	isposition (Name of crematory or other p	place)	Date	20c. Location	- City or Tow	n, State
Departm Importal any inju		21. Signature of Europa Service Licens Ronald S	Wade 101	rector	State And Baltimore		bard 655 W	. Baltim	nore St	reet
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sign d be		Part II. Other significant conditions co	ntributing to death	but not resulting in the	e underlying cause	given in Part I.		tobacco use con Yes 2 □ No		cause of death?
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his cel		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Tim Jay Year) Inju		ijury at Vork? □ Yes 2 □ N		how injury occu	ırred	
n. After this funeral d	ation	2 Accident investigation		niury - At home, farm	, street, factory, offic	ce		(Street and Num	ber or Rural	
rrier dearn. Director: After this in by the funeral d	ertification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	etc. (Specify)	,		0.13 0. 10	,		Route Number,
ifter death. Director: After this in by the funeral d	dical Certification:	3 Suicide 4 Homicide  6 Could not be determined	building, sicien: To the besiner: On the basis	etc. (Specify) st of my knowledge, of examination and/o	leath occurred at the	time, date and y opinion, death	I place, and due to the	cause(s) and m	nanner as sta , and due to t	ted.
ifter death. Director: After this in by the funeral d	Medical Certification	3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only) 2 Medical Exemi	building,	etc. (Specify) st of my knowledge, of examination and/o	or investigation, in m	e time, date and y opinion, death	I place, and due to the	cause(s) and m	, and due to t	ted. he cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Charles Henry IhomAS 9847AM 2001 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Georges Community Hospital Lanham Doctors Prince If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 217-42-0507 Director 60 Mary (and March 17,1947 Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified Director WAShingTon 1 Yes 2 No WASH, D.C. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 OXON Drive S.E. 20032 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cement Finisher Portugal Construction 12 marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 Is marked oth Thomas William HENRY Gertrude ပ MISSOUYI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 Oxon RUN DV. S.E WAShington, D.C 20032 ShirleyA. Thomas wife timore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Culpeper, virginia Fairview 14-2-07 Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2605 Do. Shirlington Road Robert B ChiNN Funeral Service ARLINGTON, V9, 22206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PULMONARY CUTE Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9□ Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Monknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Embedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 12962 March 28,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Branch Ave., Clinton, MD. 20735 acer 8909 oravda 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 02 2007 Registrar

			1 - For State Registrar	State of Maryla	ind / Depa					9007	10332
Sec	Physic /Medi		1. Decedent's Name (First, Middle, I	REUBEN	TA	LOR		2. Date of D Month MARA	eath Da	2 2007	3. Time of Death 9. SOAM
- 37	Examir	ier	4a. Facility Name (If not institution, g MERCY MEOIC.	ALCENTER	,	BAV	nor Location of Dea	CITY	7-	C. County of Death	ONE CITY
	Funeral Director		5. Social Security Number 6. Usual Residence of Decedent	Sex. 1 M 2 F	s. last birthday) Yrs.	If Under 1 Yea Months Day			ay, Year	2007 M K	place (State or Foreign ntry)
	Maryland -f ehow	tor	10a. State 10b. County	10c. C	City, Town or Lo	cation  10RE					10d. Inside City Limits 1 💆 es 2 🗆 No
	h with the	ai Direc	10e. Street and Number	implan Dr	ive	10f. Zip Code	207		10g. Ci	itizen of What Cou	· ·
5-0036	be filed within 72 hours after death with the Maryland nat Hygiene.  Identify than "natural", or items 23a or 28a-f show event, the Medical Examinar result be notified at	Completed by Funeral Director	11. Marital Status  1 Dever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces2	l l		f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ameri Black, White,	can Indian,
2121	filed within 72 ha Hygiene. other than "natu	Completed	15. Decedent's (Specify only highest g	College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti	e during most of we	orking	16b. k	Kind of Business/In	dustry
Maryland	should be fill and Mental Hy s marked oth umatic event	To Be	17. Father's Name (First, Middle, Las		(		18. Mother's Na	me (First, Middle +	, Maider	1	
	od 2 lifth a 27 to r tra		19a. Informant's Name/Relationship  MOTHER	(Турө, Print)	19b. Mailin		et and Number or R	ural Route Numb	oer, City	or Town, State, Zip	(Code) (UD 21207
saitimore,	permit. Pages 1 a Depertment of Hea Important: if item any injury or otha once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec  21. Signature of Funeral Service Lice	□Removal from State ify)  ✓ E	in Cax	sition (Name of natory or other platory) or other platory	3-3	Date 30 - 07 rad /211 -	Ba	OCATION - City or TO LAMONE KON FU	own, State  MD  LNEFAL HOME
m	202 2 3	1. 5	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the dea	ath. Do not ente	A, 2134	ring, such as cardia	S)RIN c or respiratory	CA		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ext	REM quence of):	ETT	ematru	Rity			Onset and Death
8760,	certificate be executed xx diring physician and xx se as the burial-transit and	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.		1 A	brupt	om'			Od.
. Box 6	death e atter d for u	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6	al death 3 □I	Ectopic pregnand Other (specify)	су			23d. Date of delive Month	ery Day Year
ecords, r	law requires that the de as been signed by the 2 should be detached	Š	Part II. Other significant conditions	contributing to death but not re-	sulting in the un	derlying cause g	iven in Part I.	23e. Did t		use contribute to the	ne cause of death?
Vital Reco	in: The law re ilicate has bee or, page 2 sho	e Completed	25. Was case referred to medical					1 ☐ Yes	psy ormed? 2 No	prior to cor death?	psy findings available n detion of cause of No
VISION OF VI		ToB	examiner?  1 Yes 2 No  27. Manner of Death  1 Auditural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursing H	ath (Check only of dome 5 Residence 28d. Describe	dence (	6 □Other (Specify y occurred	)
N N	s after des	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stree fy)	et, factory, office		28f. Location (: City or Tox	Street an wn, State	d Number or Rura )	l Route Number,
	n 24 hour n 24 hour ne Funers	Medicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Madical Example	nysicien: To the best of my knominer: On the basis of examination and manner stated.	thorr arroyor inve	stigation, in my	opinion, death occu	rred at the time,	date and	place, and due to	the cause(s)
	To the true to the complex com	Ž	29b. Signature and title of certifier	en MD		29c. Licen	se number	3	29d. Dat	e signed (Month, L	Day, Year)
Ò	7		30 Name and address of person who	completed cause of death (Iter	n 23a) (Type, P	rint) STPa	ul Place	BA	מת	ORE MI	7 712-2
	Stat Registra	٠ ا	31. Date filed (Month, Day, Year) APR 0 2 20	379 Registrar's Signa	Are Agos	de la companya dela companya dela companya dela companya de la companya de la companya de la companya dela companya de la companya de la companya dela company	(	, , , , , ,	,	110	2007 2007 21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Herbert H. Taggart March 27, 2007 6:38 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1919 Stanley Avenue Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 □ F Min. 84 Dec. 13, 1922 New Jersey 10d. Inside City Limits 1 X Yes 2 □ No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Insurance 18. Mother's Name (First, Middle, Maiden Surname) Barbara Johnston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3440 Gatlin Drive, Vierra, Florida 32955 20c. Location - City or Town, State Bethesda, Maryland Pumphrey Funeral Nome/ Montgomery Avenue 0-2805 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 24 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

March 30, 2007

APR 02

Leszek Karowiec, M.D. 5001 North Frederick Road, Gaithersburg, Maryland 20877 2. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Physician

/Medical

Examiner

**Funeral** 

			1 - For State Registrar	ate of Maryland / [		of Health and N	•	enn7	10334
	Physici		1. Decedent's Name (First, Middle, Last)  Melvin Taylor				2. Date of Death	ay Year	3. Time of Death 500 P M
	/Medi Examir Funeral		4a. Facility Name (If not institution, give street GOOD Saman Tan  5. Social Security Number 6. Sex	and number) +05 PI Tal 7 Age (In yrs. last bir	Bau If Under 1 Y		8. Date of Birth	Ic. County of Death	place (State or Foreign
	Director		373-42-1946 <sup>1</sup> ∑M <sup>2</sup> Usual Residence of Decedent	□F 60	Yrs. Months Da	ays Hours Min.	May 15, 1	r) Cour	nigan
	e Marylan 3a-f show diffed at	Director	10a. State 10b. County MD	10c. City, Town	n or Location Ltimore			1	0d. Inside City Limits 1    Yes 2 □ No
	ath with th	ral Dire	10e. Street and Number 115 E. Melrose Avenue	e	10f. Zip Cod	<sup>de</sup> 1212	10g. (	Citizen of What Cour USA	ntry?
980	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or Itams 23a or 28a-1 show svent, tra Medical Exertion must be trudified at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? ]Yes 2 MNo 'es, Give ar or Dates:	13. Was Decedent If Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: bla	etc.
21215-0036	i within 72 ho ilene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12)	llege (1-4or 5+)	Decedent's Usual Oc (Give kind of work do life. DO NOT use re (alesperso)	one during most of work atired)	ing	Kind of Business/Ind	
<b>Maryland</b>		To Be C	17. Father's Name (First, Middle, Last)  Andrew Taylor			18. Mother's Nam	e (First, Middle, Maide	on Sumame)	unk
	Health a tem 27 ls		19a. Informant's Name/Relationship (Type, Pr Curtis Price/executor 20a. Method of Disposition	20b. Place of	9 Homeland	reet and Number or Rur d Southway	Baltimore,	, , , , , ,	2
Baltimore,	permit. Pages Depertment of I Important: If its any njury or o		1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) in	ii irom Ştate	22. Name and Ac	ddress of Facility			
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	that caused the death. Do not see on each line.	not enter the mode of	dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	/Medical Examiner	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of the consequence of t	of):	estivisculos	) iséase	>	years
.O. Box 68	ath certifi ttending or use as	Physician/Med	in the past 12 months?	es, outcome of pregnancy ILive birth 2   Fetal death  Pregnant at time of death  Unknown	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date of delive Month	ory Day Year
۵.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contribution	ng to death but not resulting in	the underlying cause	given in Part I.		use contribute to th	
al Records,	ician: The law re certificate has be- rector, page 2 sho	Completed					24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
of Vital	Physician this certif al director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospita	1 □ Inpatient 2 ☑ ER/Out	tpatient 3 DOA	Other: 4 - Nursing Ho			)
Division of	Attending Physician: The sr death. ector: After this certificate he ector: After this certificate he by the funeral director, page	ertification;	1 Natural 5 Pending 2 Accident investigation		njury M	Work? I ☐ Yes 2 ☐ No	28d. Describe how inj		
D		O	4 Homicide determined	Place of Injury - At home, far building, etc. (Specify)			28f. Location (Street a	re)	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical		To the best of my knowledge, the basis of examination and d manner stated.					
	Twiting To		29b. Signature and title of certifier    Bulling   Flat   d cause of death (Item 23a) (  SZPO) Loc  32 Registrar's Signature	29c. Lic	73543	29d. D	ate signed (Month, l	Jeo?	
_			30. Name and address of person who complete KEVIN H. Schughs Lin	d cause of death (Item 23a) (	Type, Print) L Pavru	Boalevard	Beltom	re Man	1239 yland
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 0 2 2007	32 Registrar's Signature	Sperte		,		1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, perFH, State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Wedtn **Physician** 5:10 AM ta 200 + ore MAR 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Mercy Medical Center BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F Yrs. Sept **Director** 20,1919 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Exacultar must be tredified at 9008. 1 Yes 2 No Directo MARY MOD MORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 206 21224 U.S.A Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3™Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be HERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 206 CBORAH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3,2007 BALTIMORE, F SACRO Ht of Jesus Cen. April 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility Joseph N. ZANNINO La BA140 Conteling Street 263 5. 21224 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oncumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-tran ettending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete has b director, page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Tof 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) After thi 28d. Describe how injury occurred 27. Magner of Death 1 X Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No i Director: / d in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - Athome, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number 31,2001 MAR

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

PAUL

PLACE

BALTIMORE

MD

21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

302

SAINT

Registrar's Signature

WGN-YEE TSAI

APR 02

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TIEM#18, DerFH, G866, 472 / 07, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Terrie Yvonne Wallace 2007 26, March 11:00A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7800 Meath Road Dundalk If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-25-1957 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs 213-72-6930 Months Hours Min. 1 □ M 2 🖵 F 49 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits Director MD Baltimore 1 ☐ Yes 2X No Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7800 Meath Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **AN**0 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Kirshbaum ဂ္ William Reis Shirley <del>Kirshman</del> 19a, Informant's Name/Relationship (Type. Print)Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth A. Wallace-7800 Meath Road, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory3-31-07 Bayview |Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Fun 2134 Willow Spring Rd., 21222 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OCARDIAL /Medical Due to (or as a consequence of) Examiner PULMONARY DISEASE HACNIC OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Examine SMOKING Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has bage 2 s autopsy perforn certificate 1∐ Yes 217 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 Tyes 2 Accident 2 □ No after death Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and 29c. License number title of certifier. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 107 BEACONRD CONNELLY JR MD

Registrar

State

APR 0 2 2007 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** Month Mitchell M. Abood March 14, /Medical 2:00 P M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7900 Kentbury Drive Bethesda Bethesua

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Months | Days | Hours | Min. | Feb. 26, 1 Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🛂 M 025-16-1726 Director 82 1925 Massachusetts Usual Residence of Decedent the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Bethesda 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28 any lighty or other traumatic event, the Medical Event. 10f. Zip Code 10g. Citizen of What Country? 7900 Kentbury Drive 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 7/2/43 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. orces: 2 No 5/16/46 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify <u>Ş</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Automotive College (1-4or 5+) 5+ Elementary/Secondary (0-12) Management Level Ford Motor Co. Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Massoud Abood Elizabeth Joseph 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iola P. Abood / Wife 7900 Kentbury Dr. Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Gardens Cem. 3/19/2007 4 □ Donation 5 □ Other (Specify) Arlington, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular Accident **Physician** /Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has page 2 performed? Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After (Month, Day Year) 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1∑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0058032 March 15, 2007 m Williams DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia M. Williams DO 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State MAR 1 9 200 Registrar

07-02298

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Keith D. Bonnell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ KEITH DANIEL BONNELL Year Month Day March 25, 2007 1652 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Trevanion Rd south of Nusbaum Rd Carroll Taneytown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Michigan Months Days Hours Min Director 377-84-1733 male 2 F 1965 41 Aug. 18, Country Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Union Bridge 28a-f show Maryland Carroll Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 28a-notified at 1006 Winters Church Road 21791 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes Specify: white If Yes, Give Year unknown 4 X Divorced Widowed 1 Yes 2 X No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical telecommunications company owner Com other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donna Renny Bernard Patrick Bonnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is ۵ Donna Renny / mother 301 West Toledo Street Fremont, Indiana 46737 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State March 28, Smithsburg Crematorium important: Smithsburg, Maryland Donation 5 Other Specify 2007 22. Name and Address of Facility uneral Serv Skiles Funeral Home 136 East Baltimore Street Taneytown, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical UNPENDED AMENDED attending physician or use as the burial that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ğ Yes 2 No 3 Probably 4 Unknown Δ. pleted Records, 24b. Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy certificate has performed? ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this 1 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Mar 25, 2007 Driver auto fixed object collision 1615 hrs Natural Yes 2 V No Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
Trevanion Rd south of Nusbaum Rd, Taneytown, MD determined (Specify) Local Street 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. March 26, 2007 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar

**ORIGINAL** 

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State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Brown 24, 2245 2007 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince Georges Hospital Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) , Funeral Days Hours 1 **X**M 2 ☐ F Yrs. Director 250-22-6184 SC Aug. 12, 1922 84 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturef", or items 23a or 28a-f show other traumatic event, the Mexical Exeminar must be recitled at 1X Yes 2 No Director Orangeburg SC Orangeburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 191 Abbott Street 29018 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: if Item 27 is marked other than "nsturef", or ite 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 21 No Yes. Give Specify: Completed by 3 ₩idowed 4 Divorced Black Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wesley Brown Susie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) er 4035 Silver Park Terrace

Suitland, Md. 20746

20b. Place of Disposition (Name of cometery, crematory or other place) Christine Moorer/daughter 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or QDCE. 4 ☐Donation 5 ☐ Other (Specify) Antioch Church Cem. 3/31/07 Orangeburg, SC 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md.20746 Approximate Interval Between Onset and Death Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician thed for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 page 2 should be 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an certificate has 2 No 1 Yes 25. Was case referred temedical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 2 1 Yes 3 DOA After this 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director; A investigation 2 Accident filled in by the 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 0 LIAME HEVERIL 31. Date liled (Month, Day, Year) State APR 02 Registrar

State Registrar

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31. Date filed (Month, Day, Year) **MAR 2 1** 2007

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

vn

32. Registrar's Signature

Decem S. Speck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day 2007 Shirley Α. Berg 11 March 1445 "/Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ XF 216-03-9201 87 Yrs. Director Jan 6 1920 MD Usual Residence of Decedent the Maryland 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Finksburg Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3976 Gamber Road 21048 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) organist/pianist music 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Stansfield Alma Marie Kreiner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Steedman (daughter) 3972 Gamber Rd., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial 3-15-07 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licens Daugestaught 5 erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause oneach line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 cerchai **Physician** (cky disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Des to (or se a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🔼 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ŵo 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient P 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No neral Director; / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 052035 WIL 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

DHMH 17 Rev 1/2001

State Registrar

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March 26, 2007 James Franklin Crawford Sr. 6:25 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3824 Regency Parkway Prince George's Suitland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 28, 1957 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F 135-50-8739 49 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland 1 Maryland Suitland 5 4 1 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3824 Regency Parkway #102 20746 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Tyes 221 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) School Bus Driver P.G. County Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Crawford James Ianthia Cornelius Meeks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Crawford / Wife 3824 Regency Parkway #102 Suitland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/07/2007 Resurrection Cemetery 4 Donation Clinton, Maryland 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA neral Service License 21. Signature eles 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) adenocarcinomo Metastat month Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was autopsy performed? 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

23a or 28a-f

items

'natural', or

s 1 and 2 should be filed wing thealth and Mental Hygier them 27 is marked other the other traumatic event, the

Department of Health Important: If item 27 any injury or other to

Pages 1

the Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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Completed

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The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760 physician the as attending nse jo ed by the a ate has been signed page 2 should be det certificate has Physician:

funeral director

this After t hin 24 hours after death the Funeral Director:

or Attending

Hospital

within To the

Physician/Medical Completed by Be Certification: To filled in by

10

State Registra

25. Was case referred to medical 1 ☐ Yes 2**XX**No

2 Accident 3 Suicide 4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, 1891), APR 02

29a, Certifier (Check only one)

5 ☐ Pending investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** James Theodore Carbaugh, SR. March 18 2007 7:30 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Avalon Manor Nursing Home Washington County Hagerstown 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 12 1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. 213-42-2113 63 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17316 W. Washington Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

12. Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Maryland 21215-0036 1 ☐ Yes 🕻 ☐ No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Security Guard Security Company 12 should be filed who and Mental Hygiel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked ony Injury or other traumatic ev Omar Carbaugh Helen Knox Carbaugh 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Ann Carbaugh (wife) 17316 W. Washington St. Hagerstown Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Beaver Creek Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3-22-07 Hagerstown Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home aurtes 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on or in line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cal cancer disease or conditior resulting in death) enyna /Medical Due to (or as a consequence of): Examiner DE W Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner certificate be executed burial-trai Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 1∐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Dursing Home 5 Residence 6 Other (Specify) 2 NO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

05H-4+1

State Registrar

29b. Signature and title of certifier

M 1 n 306039

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FAR

Honord

32. Registrar's Signature

**Physician** /Medical **Examiner** 

Director

**Funeral** Director

"natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Funeral Baltimore, Maryland 21215-0036 Be Completed by ပ္ 2 Physician /Medical Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical signed by the at d be detached for page 2 s within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Medical Certification: To 29a. Certifier 10

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Matural

2 No

determined

2 Accident

3 ☐ Suicide 4 ☐ Homicide

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For	State of Ma	aryland / Depa			lental Hyg	iene	7 1001	prom
State Registrar		Cer	rtificate of	Death	Re	eg. No. 🖒 U U	1 1031	+5
. Decedent's Name (First, Middle,	Last)				2. Date of Deat		3. Time of Death	1
Chin Bing Cha	ang				March 1	15, 2007 Yea	10:15 p	, М
a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath	
Montgomery Gene	eral Hospita	11	Olne			Montgo	omerv	
Social Security Number		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	d B	Birthplace (State or Fore Country)	ign
067-26-9292	122 W 2 1	92 Yrs.			(Month, Day, Dec. 12,	1914 Ch	niná	
Jsual Residence of Decedent  0a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Lim	ite
							1 □ Yes 2 🛣	
Maryland Montgo	omery	Silver	Spring			0.000		
	ahon Drive	An+ 022	10f. Zip Code	20906	1'	0g. Citizen of What (		
15101 Interla			<u> </u>			USA		
1. Marital Status	12. Was Decedent 1 Armed Forces?	ever in U.S. 13. V	Mas Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Hace - An Black, Wh	nerican Indian, hite, etc.	
1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ☐ Yes 2 🔼 ੈ If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🖾 No	Specify:		Specify:	Asian	
15. Decedent's		162 Dooos	dent's Usual Occup	ation		16b. Kind of Busines	and Andreas	
(Specify only highest	grade completed)	(Give	kind of work done	during most of worki d)	ing	16b. Killd of Busines	s/industry	
Elementary/Secondary (0-12)	College (1-4or 5	)+)	Journalia			ederal Go	wernment	
7. Father's Name (First, Middle, Li	ast)			18. Mother's Name			Vermene	
Unknown Chang	,				known	naiden damaine,		
19a. Informant's Name/Relationship	n (Time Print)	10h Mailin	a Address (Street	and Number or Pur	al Pauta Alumbar	City or Town State	Zin Code)	
Rosalind Chang		1510	1 Interl	achen Dri	ve, #823	City or Town, State  S. Silver	Spring. MD	2090
20a. Method of Disposition		20b. Place of Dispos				20c. Location - City of		
12 Burial 2 □ Cremation	3 ☐Removal from State	cemetery, cren	natory or other plac	e) Ma	rch 19	20c. Location - City o	or Town, State	
4 □ Donation 5 □ Other (Spe		Gate of H			2007 S	ilver Spr	ing, Maryla	nđ.
21. Signature of Funeral Service Li	censee	F	Name and Addres	ss of Facility COIIIns	Funeral	Home Inc		
Lones	Only						ing, MD 20	901
23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused nly one cause on each lir	the death. Do not ente	er the mode of dying	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between	
mmediate Cause (Final disease or condition	PV	elemon	ia.				Onset and Death	
resulting in death)	Due to (or as	a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Course	
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Sequentially list conditions, fany, leading to immediate	Due to (or as	a consequence of):						
Cause (Disease or injury hat initiated events	c c							
resulting in death) Last	Due to (or as	a consequence of):						
	d.							
F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy				23d. Date of d	lelivery	
in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ∐Live birth 4 □ Pregnant at		]Ectopic pregnancy ] Other <i>(specify)</i>	1		Month	Day Year	
9 Unknown	9□Unknown							
art II. Other significant condition	s contributing to death bu	ut not resulting in the un	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?	
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					24a. Was ar autops	24b. Were a	autopsy findings availat o completion of cause o	ole of
					perform 1 Yes 2		? es 2□No	

	24a. Was an autopsy performed? 1□ Yes 2 □ No
26. Place of Death	(Check only one)

Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

nd manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

8101 PRINCE PHILIP DR. OLNE Slyam mD

State Registrar

32. Registrar's Signature Year) 19

			For State	State o	of Marylan		irtment of H		and M			UU/	10346
			Registrar  1. Decedent's Name (First, Middle,	I act)		Cer	illicate of t	Dealli		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	an	•	re Ethel	Carpon	tor				Month March	Day	Year	9:55 A M
	/Medic	_	4a. Facility Name (If not institution,			LEI	4b. City, Town, or	Location (	of Death	Haren		nty of Death	7.33 11
	Examin	ei	Montgomery Gene	-			Olney				Mor	tgome	ry
	Funeral			3. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Ye <i>ar</i> )	9. Birthp Cour	place (State or Foreign
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	pun ,		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					I1	0d. Inside City Limits
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	the N 28a-1 otifi	Director	Maryland Howa	rd	M	ount A	10f. Zîp Code				10g. Citizen o	of What Cour	ntrv?
	with 3a or 1 be r		16601 Bahner Co	nırt			21771				U.S.		,
	ms 2: mus	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \	Vas Decedent of Hi f Yes, specify Cuba	ispanic Or	igin? (Spe	ecify Yes or No-		Race - Americ	
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<u> </u>	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	l by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:		ILL Tes ZALINO	эреспу.			Spe	cify: Whi	.te
ر ا	72 h "natu dical	etec	15. Decedent's (Specify only highest	Education grade completed)	1	1 (Give	lent's Usual Occup kind of work done o	during mos	at of work	ing	16b. Kind of	Business/In	dustry
2	within	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Nur	DO NOT use retirea	1)			Ное	pital	
Maryland 21215-0036	filed v Hygie ther i		17. Father's Name (First, Middle, L	ast)		Nai	-	18. Mothe	er's Name	(First, Middle,		•	
au	d be a	Be C	Unknown						know	•		•	
$\bar{\leq}$	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	은	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	g Address (Street	and Numb	er or Run	al Route Numbe	er, City or Tov	vn, State, Zip	Code)
	nd 2 :		Ann Keating / 1	Daughter		16601	Bahner (	Court	, Mo	unt Air	y, Mar	yland	21771
ē,	s 1 a of Hea item othe		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	ce)	[	Date	20c. Locatio	n - City or To	own, State
Ë	Page nent c nt; if		1 ☐ Burial 2 【X】Cremation 4 ☐ Donation 5 ☐ Other ( <i>Sp</i>		i State		Cremator		3/1	7/07	A1exar	dria,	Virginia
Baltimore,	permit. Pages of Department of Important: If ite any injury or of any injury or of once.		21. Signature of Funeral Service L	icensee	SRR.	22	Name and Address Moleswor 26401 Ri	ss of Facili th-Wi	l llia	ms P.A.	, Fune	eral He	ome 1 20876
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the deal	th. Do not ent	er the mode of dyin	ng, such as	cardiac	or respiratory a	rest,	,	Approximate
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×	leath certific attending p	Physician/Me	IF FEMALE:	23c. If ves. or	utcome pf pregn	ancv					23d	Date of deliv	en
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., J	w requires that the d been signed by the should be detached		Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause give	en in Part	l.	23e. Did to	obacco use c	ontribute to t	he cause of death?
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ပ္တ	s bee	olete	a 8071 a	tion	DV	HUN	ngria			24a. Was		b. Were auto	opsy findings available ompletion of cause of
	The late ha	mo	7		1					autor perfo	rmed?	death?	2 No
Vita		Be C	25. Was case referred to medical examiner?					26. Place	e of Deat	h (Check only o			
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0	ding Ph h. After th funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time o Injury	Wor			28d. Describe I	how injury oc	curred	
<u>S</u>	tendi eath. tor: A the fu	cati	2 ☐ Accident investigation in	ation				Yes 2□	No	20(1 - 11 (			
Division or	or Att	Certification:	4 ☐ Homicide determine	200. Flat	e of injury - At h ding, etc. <i>(Sp</i> ec <i>i</i>	ome, farm, str <i>fy)</i>	eet, factory, office			28f. Location (3 City or Tou		imber or Run	al Route Number,
	pital ours a eral [		29a. Certifier 1 Certifying	Physician: To th	e hest of my kn	owledge, deat	h occurred at the tir	me, date a	nd place	and due to the	cause(s) and	manner as s	stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		xaminer: On the			vestigation, in my o						
	To the vithin Fo the complex c	Me	29b. Signature and title of certifier	-10		10	29c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)
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7	1		30. Name and address of person v	vho completed cau	use of death (Iter	m 23a) (Type,	Print)	212	1 1		~! -!		Numa.
_	1		Houtra	r LO	ven:	20 1	MD 18	110	12	ME	Pull	Ip b	V. MB
	Sta		31. Date filed (Month, Day, Year) MAR 2 0	2007	egistrar's Sign	ature	nach					,	
	Registi	ar			The same of	- /	And Alexander						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] 1 - For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12 Pay Mar. 20ď7 Lori Lynn Calhoun 10:12 pm /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Joseph Richey Hospice Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 1 F 545-31-0321 Yrs. Director 44 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b County 10d. fnside City Limits traumatic event, the Medical Examiner must be notified at MD Anne Arundel Glen Burnie Director 1 ∏Yes 2KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 191 Plymouth Lane, Apt. F USA 21061 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c. Depertment of Health and Mental Hygiene. Importent: If them 27 is marked other then "naturel", or item any injury or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic event. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify:White 1 ☐ Yes 2 No 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James C. Grohowski Susan Anne Allred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Grohowski/Father P.O. Box 726, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other p 20a Method of Disposition Date 20c. Location - City or Town, State Mar. 14, 2007 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Immune deficient disease Physician Acquired disease or condition resulting in death) 14 years /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) igned by the ettending physicien and be detached for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hepatitis 3 Probably 4 Unknown CIAnhosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1+c-5p1ce 1 Yes 2 No Certification: To To the Hospital or Attanding Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and C She D14383 2 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Joseph Richey Hospice Balle 170 Stand Fri 31. Date filed (Month, Day, Year) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $\boldsymbol{A}^{\,\mathsf{M}}$ MARCH 25, 2007 7:00 **EZRA DICKENS** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Fort Washington Hospital Fort Washin Washington 8. Date of Birth (Month, Day, Year) Aug. 9, 1929 Birthplace (State or Foreign Country)
 NC 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**X**M 2□ F 238-38-9312 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 No Director PG Suitland Md. 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 6806 Woodland Road 20746 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No POST— If Yes, Give Year or Dates: —KOREAN 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Body Repair Painter Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Dickens Eliza Sanders 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6806 Woodland Road
Suitland Md. 20746

20b. Place of Disposition (Namé of cemetery, crematory or other place) Darlene Dickens/wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Md. Md. Veterans Cem. 4/2/07 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 5910 Silver Hill Rd., Suitland, Md.20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): **Examiner** ALZHEIMER'S DEMENTIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【■No 24a. Was an autopsy performed? Yes 2 A No 1□ Yes Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) **Injury** 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident d in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

4

State Registrar

within 24 hours aft.

To the Funeral Di

completely filled in

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed Aprits, Day, Year) APR 0 2 2007

22. Registrar's Signature

DHMH 17 Rev 1/2001

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD# 33255

29c. License number

29d. Date signed (Month, Day, Year)
MARCH 27, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,9 per Th. 24a per verb g866 4-2-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 2007  $A^{M}$ 27, 4:10 March Denise Rae Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick College View Center Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Sejal Security Number 8. Date of Birth (Month, Day, Year)
June 15, 1 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 1970 New York <del>616-</del>54-3161 Director 36 Usual Besidence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 560 Hollyberry Way 21703 U.S.A. death v 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medikal Examine one. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**7**☐ No Specify. Specify: Ş White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Groceru 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Hagermann Cheryl L. Fry ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 560 Hollyberry Way Frederick, Maryland 21703 Ivery L. Davis, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 29 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2007 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell Canter **Physician** Metastatic disease or condition resulting in death) Squamons /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) in by the funeral 28b. Time of after death. 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury **W** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sha Frederick [ hama 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 16:42 M 2007 Robert G. Dilworth Sr 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Year) Sinai Hospital Baltimort Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. | Hours | Min. Birthplace (State or Foreign Country) 1 💢 M 2 🗆 F January 12.1930 Baltimore MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛣 No PA York Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Carson Avenue 17331 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2 💢 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Government Employee 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph G. Dilworth Ethel E. Holland 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita C. Dilworth 40 Carson Avenue, Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc. March 16,2007 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hanover. CC0354 Kenworthy Funeral Home, Inc., 269 Frederick St. PA 17331 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) severe sepsis week Due to (or as a consequence of): Acute myocardial infarction 10 days Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a soneequence of): coronary artery Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitus none insulin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

Examiner Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

burial-tran attending pl signed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p.

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f sh notified

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permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items any Injury or other traumatic event, the Medical Examiner m.

Physician

/Medical

Baltimore, Maryland 21215-0036

with the

**Funeral Director** 

Be Completed by

ည

Examiner

Physician/Medical

Be Completed

Medical Certification: To

29a, Certifier

State

Registrar

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Szalam

RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OIGH CZALASNY 2401 West Belvedere, Baltimore MD 21215

31. Date filed (Month, Day, Year)

32. Regitrar's Signature Glown

MAR 1 6 2007

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** Jerry Selby Eline 19 2007 9:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21 Thomas Schilling Ct. Upperco Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F 216-38-2870 Yrs 65 Director 1/28/1942 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahow the Madigal Examiner must be notified at 1 ☐ Yes 2X No MD **Funeral Director** Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Thomas Schilling Ct. 21155 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 □ No Yes, Give 'ear or Dates: 1 Never Married 2 Married 1960 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Completed by White 3 Widowed 4 Divorced 1968 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Depertment of Heelih and Mental Hygie
importent: if item 27 is marked other th
any injury or other traumatic avant, titta
once. Funeral Director Funeral 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Edwin Eline, Sr. Mary B. Bevard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven W. Eline - Son 3130 Eves Way Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 3/23/2007 Hampstead, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home 934 South Eline Steven M00723 Main Street, Hampstead Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac unrespiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MINUTES /Medical Due to ( se a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires thei the death certificate be executed within 24 buris eiter death.
To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nea 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number WJL 20+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwoods Trail 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 20 Registrar 2007

DHMH 17 Rev 1/2001

**ORIGINAL** 

		•	For State Registrar		State of Ma	ıryland	-	artment of I <i>rtificate of</i>			ental Hy	gien Reg. N		J	100	)
	Physici	an	1. Decedent's Name (First,	Middle, Last,	Gusta	Cra					2. Date of De	eath	X Xea	5	3. Time of Dea	ith
,	/Medio		4a. Facility Name (If not ins	titution, give	SUOTU- street and number)	100	( )	4b, City, Town,	or Location	on of Death	03	Q 3	C. Gounty of De	ath ,	X040	
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	Funeral Director		5. Social Security Number 455–12–439	4 /	7. Age	72	Yrs.	Months Days		rs Min.	B. Date of Bir Month, Da 3/18/1	915	Te	Country Xas	e (State or Fo	reign
	yland how		Usual Residence of Decede  10a. State 10b. C			10c. City,	Town or Lo	cation						10d.	. tnside City Li	mits
	8a-f sl	Director		rford		Abe	erdeen								1 ☐ Yes 2 5	No
	h with th	al Dire	10e. Street and Number 3660 Church	ville	Road			10f. Zip Code 21 001				-	itizen of What (	Country	?	
920	be filed within 72 hours after death with the Maryland hat hygiene. nd other than "naturel", or iteme 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div	Married	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:			Was Decedent of f Yes, specify Cut			ify Yes or No ican, etc.)	0-	14. Race - An Black, Wh Specify: Wh	nite, etc		
5	72 ho "natur	eted	15. De (Specify only	cedent's Edu highest grad	cation e <i>completed</i> )		16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during n	nost of working	,	16b. I	Kind of Busines		try	
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Maryland 21215-0036	should be and Menta marked umatic ev	은	Edward Gus				19h Mailin	ng Address (Stree		Blanche		ner City	or Town State	Zin Co	ode)	
	s 1 end 2 should f Health and Mer item 27 ie marke other traumatic		Joel D. Gus					Churchvi					Marylan		21001	
Baltimore,	Page nent o int: if		20a. Method of Disposition  15€ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot		lemoval from State	Ce	metery, cren	sition (Name of natory or other pla metery	100)	3/28/			ocation - City o			
Balti	permit. Departm Imports any inju		21. Signature of Funeral So	ervice Licens	/	Se		Name and Addr arring—C berdeen,	ess of Fa argo	Funera	al Hom	ne, ]	P.A.			
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7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Card	oge	nic	Shoc	k_					Z	nset and Deat Lay	5
	Examiner		Sequentially list conditions	1.	Acut	conseque	My	o card	ial	2 In	faro	fic	N	2	day	5
12	ed sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·₹	Due to (or as a	conseque	ence of			7						
والر	execut on and rial-tran	Examiner	that initiated events resulting in death) Last	(	Due to (or as a	conseq	ence of):	77-5	7 4	7500						
68760,	ifficate be executed g physicien and as the burial-transit	edical			J											
Вох	ath certif ttending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	arit	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal o	death 3□	Ectopic pregnance Other (specify)	:y				23d. Date of d Month	delivery Da	ıy Year	
ls, P.O.	res that the de signed by the a I be detached f	by	Part II. Other significent co		ntributing to death bu		-	nderlying cause gr	ven in Pa	art I.			use contribute	to the o		
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to m examiner?		fospital:			1.0		ace of Death (			<u> </u>			3
Division of	ding Phys h. After this funeral dii	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 F 2 Accident	Pending nvestigation	28a. Date of Injun (Month, Day	y :	P/Outpatien 28b. Time of Injury	28c. Inju		28	e 5 ☐ Resi ld. Describe		6 □Other (Sp ury occurred	oecify)		
Divisi	in Dire	Certification:	3 Suicide 6 □ 0	Could not be determined	28e. Place of Injubuilding, etc.	ry - At hor . (Specify)	ne, farm, stre	eet, factory, office		28	f. Location ( City or To		nd Number or (e)	Rural R	oute Number,	
	e Hospital or 24 hours afte e Funeral Dir lietely filled in	edical C	29a. Certifier 1 Certifier (Check only one) 2 Me	ortifying Phys odical Exami	sician: To the best o ner: On the basis of and manner stat	examinati	rledge, death on and/or inv	occurred at the trestigation, in my	ime, date opinion, d	and place, and death occurred	d due to the at the time,	cause(s	s) and manner od place, and d	as state	id. e cause(s)	
	To the I within 2. To the I complet	M	29b. Signature and title of c	certifier	7			29c. Licen					ate signed (Mo			
			30. Name and address of p	erson who co	Months of designation of designation of designation of the designation	ath (Itam	23a) (Type	Print)	27	22	2	M	arch	22	, 20	07
	0		Paul L	He.	Do =	207	5, L	NION	A	ve	Har	re	De G	re	ce r	10
	Sta Registr	-	31. Date filed (Moeth, Day,	2 2007	2. Registra	r's Signati	ire chart	W							7	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** рМ Pedro Alonso Gonzalez March 15, 2007 8.55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery Olney If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 X M 2 □ F 579-04-1323 58 Director Dec. 5, 1948 Nicaragua Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show on notified at 1 ☐ Yes 2 ☐ No Maryland Montgomery Rockville Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n 4715 Aspen Hill Road 20853 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? "natural", or items Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Nicaraguan Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Technician Biotech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 27 Is marked of traumatic ever Daniel Calero ပ Ignacia Gonzalez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau 4715 Aspen Hill Road, Rockville, MD 20853 Juana F. Garcia/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition March 20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ANDREC ENCEPHALCEATHY 2 wights **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5-10-11 (ARDIOMYLAATHY Sequentially list conditions, if any localization cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month ξō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, b RENAL FAZELRE 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Ste, by locairel SEPSIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy DIABEIEI performed 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 023630 MARCH 16, 2007 - show au (11811 234) (1994, Print)
11226 FREDER ECK RD 4213 GASTHERS BURG, MD 20877 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAYE, MA 32 Registrar's Signature 31. Date filed /M State 2007 Registrar

	1 - State Registrar			Cert	ificate of	Death			Reg. N	ie 10. 2 1	007	1 100
	Decedent's Name (First, Middle, I	Last)						2. Date of D	Death		UUI	3. Time of De
an	Michael Da	niel	Gibb	oone				Month March	16.	ay 200	Year 7	10:07
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	Montgomery Gene  5. Social Security Number 6	ral Hospita Sex 7. Ag	je (In yrs. last	birthday)_	If Under 1 Year	If Under		8. Date of E	Birth		gomer 9. Birthp	place (State or Fi
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Directo	10e. Street and Number				10f. Zip Code				10g. C	Citizen of N	What Cour	ntry?
	28926 Poplar G	rove Road				9968						SA
runeral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Oi an, Mexica	igin? (Span, Puerto	ecify Yes or N Rican, etc.)	No-		ce - Americ ck, White,	
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2	3 ☐ Widowed 4 🖺 Divorced								Line	1		
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2	19a. Informant's Name/Relationship	(Time Print)	1	IOb Mailina	Address (Street	and Numb	or or Dur	al Pauta Num	abor Cit	. or Town	State 7:	- Codo)
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- 1	20a. Method of Disposition	21001101	20b. Place	e of Disposi	ition (Name of	,		Date	-		- City or To	
-	1 ⊠ Burial 2 □ Cremation 3		ceme	etery, crem	atory or other place aven Cem		Maı	ch 20	2001	Location	Only of 10	omi, otato
	4 Donation 5 Other (Spe		- Su CC			1		2007	Sil	ver S	Sprin	g, Mary
	21. Signature of Funeral Service Lic	censee		fr	Name and Addre	COI	ins	Funera	al H	ome ]	Inc .	
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State Registrar 31. Date filed (Month, Day, Year) BAR 1 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** P M Charles Thomas Grimes March 16 2007 3:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1954 MD **Funeral** Hours Months Days 1 M 2□F 212-68-2278 52 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No MD Frederick Middletown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be 2508B Station Rd. 21769 USA Funeral Pages 1 and 2 should be filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 Widowed 4 Divorced "natural"; Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) 12 security officer contracting h and Mental Hygie 7 Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Garnett Grimes Ruth Virginia Stream ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6626 Manor Woods Rd., Frederick, MD 21703 of Health a Tonya Beitzel (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 2 Cremation 3 Removal from State 1 X Burial Boyds PresbyterianCem.3/22/07 Boyds, MD n 5 Other (Specify) 4 Domati Donald B. Thompson Funeral Home P. O. Box 18, Middletown, MD 21769 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to initire diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 1 Inpatient မှ 1 Yes 2 ER/Outpatient 3 DOA After this funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 😢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 ☐ Medical Exa niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours To the Funeral C

State

29c. License number 29d. Date signed (Month, Day, Year)

-0-

Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, the attending physician peen has certificate this After

after death Director:

Physician

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinar

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

Director

Funeral

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Certification: To

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29a. Certifier

death with the Maryland

Hospital or Attending filled in by within 24 hours a completely

WH 25+1 State

> Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 2 1 2007

29b. Signature and title of certifier

Madhan

WASHINGTON COUNTY HOSPITAL 251 E ANTIETAM STREET HAGESTOWN MARTIAND 21740 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAVL HUBBLY

Hulobly,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D62562

29d. Date signed (Month, Day, Year)

2007

For

			Registrar					Ce	rtifica	te of	Death	7		A	leg. No.		
	7 - 7 3		1. Decedent's Name (First, Mic	dle, Last)										te of Dea		Year	3. Time of Death
	Physici		Lena Audre	y Hu	nter									rch	25,	2007	15:28 PM
/Medica Examine			4a. Facility Name (If not institution, give street and number)  Laurelwood Care Center					4b. City, Town, or Location of Death <b>Elkton</b>						4c. County of Death  Cecil			
	Funeral Director		5. Social Security Number <b>217–22–8807</b>	6. Sex	( ]M 2 <b>⊠</b> F	7. Ag	e (In yrs. la 79	st birthday) Yrs.		or 1 Year Days	ff Unde Hours	r 24 Hrs. Min.	8. Da	te of Birth onth Day	927	Cou	oface (State or Foreigr ntry) ryland
7	P _		Usual Residence of Decedent				10c. City, Town o	<b>Y</b>							1011		10d. Inside City Limits
1215-0036 within 22 hours after death with the Maryland	e Maryiar e-f show	ctor	MD Ce	cil_				rt De									1 ☐ Yes 2 🕅 No
	or 28	To Be Completed by Funeral Director	10e. Street and Number					10f. Zip Code						10g. Citizen	of What Cou	-	
	s 23a		19 Laredo Lane					1.0	21904						14.5	U.S.	
	s 1 and 2 should be filed within 72 hours after deeth with the Marylan I Heath and Mental Hyglene. Item 27 is marked other then "neturet", or items 23a or 28a-f show item 27 is marked other then "neturet", or items 23a or 28a-f show other traumatic event, the Masdical Exemples mainter notified at			. Marital Status  1 Never Married 2 Married  3 MEWidowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:				etc.)	Black, White, etc.  Specify: White		
	2 hou		15. Deced	ent's Edu	ducation 16a Dece			dent's Usual Occupation kind of work done during most of working DO NOT use retired)					16b. Kind o	f Business/In	ndustry		
	hin 7.		(Specify only high Elementary/Secondary (0-12	T	Coflege		5+)	life.	DO NOT	ork done use retire	auring mo d)	ist of work	ing	1			
7	d with		12		0			U	S G	over	nmen					il Serv	vice
Maryland 21215-0036	2 should be filed within n and Merial Hygiene. I is marked other then "reumatic event, the Mar		17. Father's Name (First, Middle, Last)  Robert S. Stephens					18. Mother's Name (First, Middle, Maiden Sumam <b>Lena DeBaugh</b>							name)		
	2 sho and ? is ma		19a. Informant's Name/Relation	nship (Ty	pe, Print)			19b. Maili	ing Addre	ss (Street	and Numb	ber or Run	al Rout	e Numbe	r, City or To	wn, State, Zip	o Code)
	1 and Health em 27		Robert Hunt	er (	son)		20h Die				me,		De Date	posi		21904	
Baltimore,	permit. Pages 1 are Depertment of Heal Importent: If Item 2 any injury or other 2005.		20a. Method of Disposition  1 □ Burial 2 K Crematio 4 □ Donation 5 □ Other		lemoval fron	n State	Cei	ace of Disper metery, cre A. Fer	matory`or	other pla				)7		on · City or T hester	
	permit. Depertn Imports any inju		21. Signature of Funeral Servi	e License	00			2		hêll	ss of Saci	ith 1	Fun	eral	Home	, P.A.	
ם פ	89 5 9		221. Signature of Funeral Service Licensee  221. Signature of Funeral Home, P.A.  123 S. Washington St., Havre de Grace, MD										race, MD				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate finterval Between														
1. 185	Physician		Immediate Cause (Final disease or condition a MYOUSOIAL TNRE7101									Onset and Death					
	/Medical		resulting in death)		b												
	Examiner		Sequentially list conditions,	l b													
\	be sit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	₹													
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00/00	certificate be executed thing physicien and ise as the burial-transit		d. CAS														
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	2	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown				January 11 January 11					23d. Date of delivery Month Day Year			
	that ned by deta		Part If. Other significant cond	itions cor									3e. Did tobacco use contribute to the cause of death?				
	w requires that s been signed to should be deta													1 Yes 2 No 3 Probably 4, 10nkm			bably 4.20nknown
	s bee	ojete											2	ta. Was		4b. Were aut	opsy findings available
Ľ	The la te has age 2	on: To Be Completed											1	autop perfoi ⊒ Yes	rmed?	death?	ompletion of cause of
Division of Vital Records, P.O. Bo	len: rtifica tor. p		25. Was case referred to med	cal							26. Pfa	ce of Deat				103	
	ysici Is cel direc		examiner?									fy)					
	ng Ph ter th neral		27. Manner of Death  Natural 5 □ Pen	dina	28a. Date of Injury (Month, Day Year) 28b. Time of Injury									8d. Describe how injury occurred			
	endir sath. or: Af he fur	atic	2 Accident investigation (World, Day 1997) Injury Work?  1 Yes 2 No														
	To the Hospitel or Attending Physicien: The law within 24 burus eiter death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2.	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)											(Street and Number or Rural Route Number, rown, State)			
			29a. Certifier  (Check only one)  (Check only on										stated. to the cause(s)				
	of the Mithin Somple	Me															
	> - 0		> Allton.						1)54073						27 MAR 07		
	1		30. Name and a dres pes	on who co	ompleted car	use of	death (Item	23а) (Туре	, Print)		, -	, ,	\	(			1
	5	1 3	Apin Stoke	M	(	917	CF	WZCHI	naus	(-	2	1	1 EN	G15	TE D	E /	1720
	St	ate	31. Date liled (Month, Day, Ye	ar)	32.	Registi	ar's Signati			_						170	
	THE RESERVE OF THE PERSON NAMED IN				400		6 4		of a								

State Registrar DHMH 17 Rev 1/2001

APR 0 2 2007

		1 - For Amend #2 p	State of Marylar er FCHD, #8 p	nd/Dep er FH (	artment of 03-23-20 rtificate o	Health and 07 CNM Death	Mental Hy	giene Reg. No 0 0 7	10358				
Phys	sician	1. Decedent's Name (First, Middle, Lat		2. Date of De <b>03</b> th 17	-2 <b>007</b> Year	3. Time of Death							
_	edical	Jessica Diane Howard  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death						March 17, 2007 9:3					
Exa	miner		4c. County of Death										
		3707 Blueberry D 5. Social Security Number 6. S		last hirthday	Monro		S. 8 Date of Bir	Frederi	_				
Fune: Direct		5. Social Security Number 212-27-2476 6. Sex 1 Months 1 M											
aryland ahow	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🗓 No				
the M 28a-f	ecto	Maryland Freder  10e. Street and Number	10- 0:4										
with Ba or	وَ	1080 Carlton Pla	ce - Apt. TD		10f. Zip Code 2170			10g. Citizen of What Co	untry :				
death ms 23	lera	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent o	f Hispanic Origin?	Specify Yes or No		ncan Indian,				
parifiliore, IMATYIAIIIQ Z.I.Z.I.3-0030 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than *natural', or items 23e or 28e-f ahow many injury or other traumatic event, the Marical Examinat must be multipled.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 📉 N	o Specify:	rto Rican, etc.)	Black, White					
72 ho	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Student							ndustry				
Z1Z15-0U35  od within 72 hours af giene.  or then "natural; or , the Medical Exam	a se	Elementary/Secondary (0-12)											
Ned w	Ö			St	udent	1		Student					
Maryland  1d 2 should be file  Ith and Mental Hy  27 is marked oth	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame)											
Mary 12 shound hand h		19a. Informant's Name/Relationship (	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Healt		Phyllis Jean How 20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of	- 10	Date	20c. Location - City or					
DAILLIMORE, Dermit. Pages 1 e Department of Hez mportent: If Item any Injury or othe		1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	matory or other p Heaven								
ILTIN		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer			neaven 2. Name and Add		21/07	Silver Spri	ng, Maryland				
D Pegen	SDC	Heather	m. Wolf		Moleswo 26401 1	orth-Will Ridge Roa	d, Damas	., Funeral l cus, Maryla	nd 20872				
Physicia /Medic Examin	al	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Acute Myeloid Leukemia  Due to (or as a consequence of):											
ecuted and -transit	e la	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect consec										
ob/ou, tificate be ex g physicien as the burial	Caj		d.										
the death cer y the attendir	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown		23d. Date of delivery  Month Day Year								
uires that n signed b	d by Pi			Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown									
OVISION OF VICE INCOMES IN A STANDARD THE NAME OF THE NAME OF THE NAME OF THE O	Completed					perfo	tvas an utopsy enformed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
VILC ician certifi ector	Be	examiner?	26. Place of Death (Check only one)  Hospital:   Innation: 2 FB(Outnation: 2 DOA Other: 4 Described on the Company of Check only one)										
ding Physician: The law h. After this cardificate hes funeral director, page 2	tion: To		28a. Date of Injury (Month, Day Year)	28b. Time o Injury	" 3LI DOA		me 5 ☐ Residence 6 MOther (Specify) House 28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, str fy)									
Hospital or 124 hours efter Funeral Director in Fluid in letely filled in	Medical												
To the Vithin 2 To the Complet	<b>≅</b>	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Y					
0		<b>)</b>	alexans		D5	2777		March 19,	2007				
1		30. Name and address of person who			•								
		David Mark Loeb	, M.D. 1650 0	rLeans	Street,	, Baltimo:	re, Mary	Land 21231					
	State istrar	31. Date filed (Month, Day Year) MAR 2 0 2	32. Registrar's Signa	J. A.	one								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** A M 7:15 MARGARET CATHERINE HARFORD March 19 2007 \*/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospital Center Westminster
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept. 19,1915 5. Social Security Number 212-74-0315 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F Director 91 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show at 1 ☐ Yes 2 No MD Baltimore "natural", or items 23a or 28a-f shedical Examiner must be notified Upperco Director 10g. Citizen of What Country? 10e. Street and Number 5405 Arcadia Ave. 10f. Zip Code 21155 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or the of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 🛣 No Specify: Specify: White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Augusta Hampt Goldie Mildred Shaffer 2 other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. S. Jayne Martin/ Daughter 2825 Ebbvale Rd., Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 TBurial 2 □ Cremation 3 □ Removal from State Evergreen Memorial 03/21/2007 Finksburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee 934 S. Main St., Hampstead, MD M00723 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury rial that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2☐₩0 3☐ Probably 4☐Unknown 1 ☐ Yes Completed arkinguls di 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 NO Certification: To 1 ☐ Yes npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner 1 atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the 29b. Signature and 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Kaman B. Kaheua 3 due. Malcalm

State Registrar DHMH 17 Rev 1/2001

32. Registrar's Signature MAR 20 2007 GOBALL

Kaman

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **3** 2007 2/ Gary Johnson 4c. County of Death 4b, City, Town, or Location of Death . Facility Name (If not institution, give street and number) Wicomica ENINSULA LENTER ISBURY EGIONAL EDKAL Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 17 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday 5 Social Security Number Year Months Days Hours Min. 1⊠M 2□ F Maryland 47 212-72-2201 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 → No Marion Station Worcester MD10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21863 USA Ward Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Gravel Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vivian Johnson Wilbur Ewell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Station, Maryland 21863 Bernard Johnson/Brother 20c. Location - City or Town, State 2 1863 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Land Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 24, 2007 Marion Station, MD Johnson Family Cem. 22. Name and Address of Facility 21. Signature of Funeral Service License Salisbury, Maryland P.A. - 1213 Jersey Road 21801 Jolley Memorial Chapel, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter or denying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1☐ Yes 2☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

Director

Funeral

þ

Completed

with the Maryland

filed within 72 hours after death

Hygiene.

the

permit, Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumarite.

Baltimore, Maryland 21215-0036

certificate be executed and burial-tra P.O. Box 68760, attending physician the as ise ō the signed by Division or Vital Records,

Examiner Physician/Medical ģ Completed Be

ပ

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 3 ☐ Suicide

6 ☐ Could not be determined

M. D.

1 XInpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year)

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

4 ☐ Homicide

🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SAUSBURY

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 100 6 CARROIL ST. 2. Registrar's Signature

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 8 2007 Goldie Arvella Jones /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🛛 F **Director** 11,1930 301-26-0898 Jan. West Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mea Call Examiner must be notitited at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18004 Putter Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Assembler</u> Fitting Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ <u>George Arnold Bergdoll</u> <u>Hattie Rebecca Shumaker</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Jones - Son 7849 Mt. Laurel Rd. Boonsboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) 4 ☐ Donation Cedar Lawn Mem. Park | Mar.21,2007 Hagerstown, Maryland 21. Signature of Service & Oshorme Adrene Fally Home, P.A. 1 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. 5/11, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock of pleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat use (Final disease ondition resulting in death) **Physician** throm /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 2 has been sig ge 2 should b 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performé page certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Apatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No i Director: / 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours at the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) ٥

WH-3

State Registrar 31. Date filed (Month, Day,

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 4:07 PM Donald William Kane March 17 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Rithplace (State or Foreign Washington County Hospital Hagersotwn Age (In yrs. last birthday) Birthplace (State Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sex 14 M 2 ☐ F Days 73 April 3 1933 west Virginia 220-28-3270 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Washington Hagersotwn 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 546 N. Locust Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race · American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 💹 No Specify Specify: 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Spring Works Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lenard L. Kane Fannie V. Orr Kane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (wife) 546 N. Locust Street Hagerstown Maryland 21740 Cora Kane 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 □Removal from State 4 □ Donation 5 □ Other (Specify) 3-19-07 Smithsburg Maryland Smithsburg Crematory 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd N., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) NOSOCOHIAL PUBLIFORIA IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical **Examiner** 

and

physician

the

certificate Physician:

this

After Attending death

within 24 hours after death To the Funeral Director:

completely

ō Hospital **Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at

should be filed within 72 hours after ind Mental Hygiene.

and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun

3altimore, Maryland 21215-0036

/Medical

10a State

Director

Funeral

2

Completed

Be

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burial-trar the signed by t t be detach page 2 should funeral director,

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Be Completed Certification: To filled in by

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated

24a. Was an autopsy

20 No 26. Place of Death (Check only one

24b. Were autopsy findings available prior to ∞mpletion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2	ĺο	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 [	OOA Other: 4	☐ Nursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, stree	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 470 872567, HAGENOTOWN, HD, 21742

54-1+1 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 21

32. Registrar's Signature

			For State	State of	Marylan				d Mental F		2007	100	262
			Registrar	4)		Cei	tificate of	Dealli	2. Date of	Reg. No.		3. Time of	Dooth Dooth
	Physicia	an	Decedent's Name (First, Middle, Language)						Month	Day	Year		
	/Medic		Dorothy Louise	Kimmel			4b. City. Town,	and anoting of F		18, 2	County of Death	1:18	a. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi		iber)				) <del>e</del> atri				
100 M			Rockville Nursin  5. Social Security Number 6.		7. Age (In yrs.	last hirthday)	If Under 1 Year	ville	Hrs. 8. Date of		ontgome	place (State o	r Foreign
	Funeral Director			1□M 2⊠F	• , ,	86 Yrs.	Months Days		Min. (Month,	Day, Year)	CoL	intry) [ndiana	
100			Usual Residence of Decedent			00			Teb.	11, 1		inatana	
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside Cit	ty Limits
	Mar.	ţ	Maryland Montgo	omerv		Gaith	ersburg					1 🗆 Yes	2 🔀 No
	n the	Directo	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?	
	th wil		572 Orchard Ri	idge Driv	/e, Uni	t 100	20	878		τ	JSA		
	ems	Funerai	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Origin oan, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No- 1	<ol> <li>Race - Amer Black, White</li> </ol>		
20	or it	Y.F.	1 Never Married 2 Married	1 ☐ĀYes If Yes, Giv	2 □ No e		1 ☐ Yes 2 No	Specify:			Specify: Wh:	ite	
21215-0036	72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show idical Examinar must be notified at	d by	3 XWidowed 4 Divorced	Year or Da	1943	-1945	4			105 Kin	nd of Business/li	a di votati s	
Ç		iete	15. Decedent's E (Specify only highest gi	rade completed)		(Give	tent's Usual Occu kind of work done DO NOT use retire	during most of	f working	100, KII	id of business/ii	loustry	
7		Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		Register				Hea]	lth Car	·e
	illed wi Hygien other th	Ö	17. Father's Name (First, Middle, Las	(t)		1	<u> </u>		Name (First, Mid	dle, Maiden	Surname)		
a	2 4 5 5	To Be	Consti - Conith					7	Donothe	Chim	1 4 20 00		
Maryiand	should nd Mer marke umatic	ř	Curtis Smith  19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t and Number o	r Dorothy or Rural Route Nu	mber, City or	Town, State, Z	ip Code) 20	878
<u>8</u>	os 1 and 2 should bot Health and Ment Iftem 27 le markect rother traumatice		Marybeth Milcetic	th/ Daugh	nter				ive, Uni				
ā,	Hea Hea tem othe		20a. Method of Disposition	Jii, Daugi	20b. P	Place of Dispo	sition (Name of natory or other pla		Date	20c. Lo	cation - City or T		, 110
0 E	Pages nent of ant: If it ury or o	-	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		State		itan Cre		March 1 2007	.9 Alex	andria,	Virgi	nia
altimore,	artine ortan		21. Signature of Funeral Service Lice			22	Name and Addr	ess of Faculity	ins Fune		<u>.</u>		
ñ	permit. Pages 1 Department of H Important: If Ite eny injury or ott		1	Ocal	٥.				Blvd, W.,			a~ MD	20001
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8	/Medical		disease or condition resulting in death)	aDue to (	rond! or as a conseq		arteri	1 0	13 4404			yea	1.0
П	Examiner					1	/					,	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseq	uence of):							
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Ö,	e exe ian ar irial-t		resulting in death) Last	Due to (	or as a conseq	uence of):							
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9	artific ing pl	Med	IF FEMALE:										
Rox	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	ıl death 3 [	Ectopic pregnanc	су		2	3d. Date of deli-	,	rear
	at the dea by the a tached fa	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn. 9□ Unkno	ant at time of down	leath 5	Other (specify)			-		,	
J.	hat thid by	Ph	Part II. Other significant conditions	contributing to de	ath but not res	uiting in the u	nderlying cause d	ven in Part I	23a. D	id tobacco us	se contribute to	the cause of d	eath?
Records,	w requires that been signed b should be deta	Completed by	Condestive	hea	int -	Pailu	noonying oddso g n≠	ivoir iir r airt i.		\	,	babiy 4 □l	
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									1 🗆 Ye		1 Tes	2 X No	
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			_ 0	/	Death Check or				
	Phys this ral dia	٦.	1 Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpatier 28b. Time of	it 3L DOA	4 X Nursi	ng Home 5 ☐ R	esidence 6		ify)	
S	ding P. h. After funera	ţ	1 Natural 5 ☐ Pending	(Mont	h, Day Year)	Injury	W	ork? ∐Yes 2∐No		,,	, 000000		
Division of	deat deat ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not	be 380 Blace	of Injury - At h	ome, farm, str	eet, factory, office			n (Street and	d Number or Ru	ral Route Num	ber,
2	after Dire	Certification:	4  Homicide	buildir	ng, etc. (Specif	(y)	,		City or	Town, State)			
	To the Hospitel or Attending Physicien: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.			hysician: To the									
	n 24 I	Medical	(Check only 2 Medical Exa	aminer: On the ba and manr		ation and/or in	vestigation, in my	opinion, death i	occurred at the tir	ne, date and	place, and due	to the cause(s	)
	To the To the To the Comp	ž	29b. Signature and title of certifier	/	) 4	11 a. b	29c. Licer	se number	(0	29d. Date	signed (Month	, Day, Year)	287
			> fatricia	10msk	co 1	lag, n	ov	1519	16	Mai	nch i	8,20	101
7	7+1		30 Name and address of person who	o completed caus	e of death (Item	n 23a) (Type,	Printy //	D-1.	0 10-	n 1.	-11	1110 -	
			Patricia lomski	) Nay	MV, 111	19 KG	CKVILLE	rike,	6-100,	KOCKI	11/1e, 1	VIV 20	1852
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12	Registr	ar		14	CHILLES .	10. 10							

			1 - For State Registrar	State of Marylan		artment of Heatificate of De	eath	Reg	ene 2 0 0 7	10364
	Physici /Medio Examin	cal	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give s		ATH	4b. City, Town, or Lo		2. Date of Death Month MARCI+	Day Year 12 2007 4c. County of Death	
	Funeral Director		213-01-3717		* -			8. Date of Birth (Month, Day, Y Jan • 19,	Anne A 1920 Ma	rundel place (State or Foreign intry) aryland
	Be-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Anne An		y, Town or Lo Severna	Park				10d. Inside City Limits 1 ☐ Yes 2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tien 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other treumatic event. The Medical Examinar invest to incitied at page.	Funeral Director	10e. Street and Number 43 West McKinsey  11. Marital Status	Road Apt. 2  12. Was Decedent Ever in U. Armed Forces?		10f. Zip Code 211  Was Decedent of Hisp f Yes, specify Cuban,			J. Citizen of What Cou USA 14. Race - Amer Black, White	ican Indian,
5-0036	72 hours afte natural', or it lical Examin	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade	cation	II		Specify:	16	Specify: W	hite
1 2 1 2 1 t	a filed within a Hygiene.  Other then "rent. Ine Met.	Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	ond Surveyo	OT 3. Mother's Name	(First, Middle, Ma		ne, Jr., Inc
Maryland 21215-0036	id 2 should be the and Menta 27 ie marked 17eumatic ev	ToB	Fayette Latham  19a. Informant's Name/Relationship (Ty. Patricia Latham/Da		1	ng Address (Street and	Number or Rural		City or Town, State, Zi	
Baltimore,	. Pages 1 ar Iment of Hea tant: if item jury or other		20a. Method of Disposition  1 Burial 2X Cremation 3 R  4 Donation 5 Other (Specify)	lemoval from State	emetery, crer letro C	sition (Name of natory or other place) rematory	200	7	c.Location - City or T Baltimore,	
Ba	permit Deparimpor impor eny in		21. Signature of Poneral Service License  23. Parl. Enter the disease, or compli	fications that caused the deat	4	Name and Address (Barranco & 195 Gov. Ri	itchie Hw	y. Seve		Funeral Home MD 21146 Approximate
	The price of the p	l Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Lint or Jonyling Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	ED DE	MONT	VA		Interval Between Onset and Death
	The law requires that the death certilicate bise hes been signed by the attending physic page 2 should be detached for use as the b	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	I death 3	Ectopic pregnancy Other (specify)			23d. Date of delin	very Day Year
cords, P	requir	Completed by P	Part II. Other significant conditions cor	ntributing to death but not res	_	nderlying cause given	in Part I.	1 ☐ Yes 24a. Was an	24b. Were aut	obably 4 Unknown
Vita	ysician: s certifice director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	Othor	6. Place of Death		death?	ompletion of cause of  2 No
Division of	Jing P J. After t funera	Certification: T	27. Manner Death  1 Instural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? M 1 \( \text{Ye}	t 20 s 2   No	8d. Describe how		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Certi	29a. Certifier 1 Certifying Phys	sician: To the best of my kno ner: On the basis of examina	y) wledge, deati	occurred at the time,	date and place, as	City or Town,  nd due to the cau d at the time, date	se(s) and manner as	stated. to the cause(s)
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	+1 v#	ate	30. Name and a ress of person who co	ANY COM MU	860 ature	Veregones	HIGHNAY	Muse	esnup M	2007
	Sta Registi		31. Date filed (Month, Day, Year)	R 1 6 2007	ature	B South	20	/		

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		4	1 - For State Registrar	State of Ma	ryland / De <sub>l</sub>	oartmen e <i>rtificat</i> e			and Me		iene <sub>og. No.</sub>	07	10365
	Physici	an	1. Decedent's Name (First, Middle, Las	(t)					2	2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Robert	Franklin	McGaha					arch	<del></del>	2007	6:00 a.M
	Examir	ner	4a. Facility Name (If not institution, give					Location o	of Death			ty of Death deric	
	F		4025 Crow Rock R 5. Social Security Number 6. S		(In yrs. last birthda		ersv:	If Under	24 Hrs.   8	I. Date of Birth		9. Birth	place (State or Foreign
	Funeral Director		217-32-6762	M 2□F	70 Yrs.	Months	Days	Hours	Min.	(Month, Day, arch 20	Year)	Cou	ryland
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Maryll	ō	Maryland Frederi	o le	Myersvi	110							1 ☐ Yes 2√ No
	r 28e	rec	10e. Street and Number	CK	Myersv.	10f. Zip	Code			1	0g. Citizen o	f What Cou	intry?
	th with	Funeral Director	4025 Crow Rock Roa	ad		2	1773				USA		
	ems erm	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	Was Deced	ent of Hi	spanic Ori	gin? (Speci	fy Yes or No- can, etc.)		ace - Ameri ack, White	can Indian, etc.
36	s afte	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If <del>Ye</del> s, Give	o	1 ☐ Yes		Specify:			Spec	16	nite
9	hour	ed b	15. Decedent's Ed		55-58 16a. Dec	edent's Usua	al Occupa	ation			16b. Kind of		
21215-0036	nin 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Gi	ve kind of wor . DO NOT us	rk done d se retired,	turing mosi )	t of working	7			,
21	od with	moC	10	Conlege (1 4015		tenanc	e Me				HVAC		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturer, or items 23e or 28e-f show any injury or other treumetic event. If a Medicul Evaruar trimit be notified at once.	Be	17. Father's Name (First, Middle, Last) George Franklin	McGaha						First, Middle, I	1.00	,	
ryla	d Men marke	To	George Franklin  19a. Informant's Name/Relationship		10h Ma	iling Address	(Street o		theri	ne Lou Route Number		anne i	
Ma	d 2 sl th an t7 is r treur		Patricia McGaha	,, ,									1 21773
ē,	Heal Heal tem other		20a. Method of Disposition	,	20b. Place of Dis	position (Nan	ne of	I	Dat		20c. Location		
OE.	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Harmony	rematory`or o Cemet		M	ar.30	, 2007	Myersy	ville	, Maryland
altimore,	mit.   partm sorte r inju		21. Signature of Funeral Service Licen			22. Name an	d Addres	s of Facilit	у	504	Main S	Street	t .
ñ	P C E G		aff Chatell		Ì	ickett	s Fu	mera.	1 Home	e Myer	sville	e, MD	21773
			23a. Part1. Intel the risease, or com shock, of leart failure. List only	olications that caused one cause on each lin	the death. Do not e	nter the mod	e of dying	g, such as	cardiac or i	respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		-UNE (	mec	_						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):								
		<u>ا</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):							-	
List	uted I	Examiner	cause. Enter Underlying Cause (Disease or injury										
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8760,	te be ysicia ne bur	cal	(	d									
9		Physician/Medi	IF FEMALE:										
Вох	ath certif attending for use as	ian/I	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B □Ectopic pr						ate of delivitionth	ery Day Year
P.O. I	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	Other (sp	ecity)						•
	n requires that the death been signed by the atte should be detached for	/ Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the	underlying c	ause give	en in Part I.		23e. Did toi	bacco use co	ntribute to	the cause of death?
Sp	uires sign ild be	d by								1 ₫ Ye	es 2 No	3 ☐ Pro	bably 4 Unknown
Ö	aw requas been 2 should	lete								24a. Was a	n 24b	. Were aut	opsy findings available ompletion of cause of
Re	The lav	Completed								autops perform	ned?	death?	
ta	icien: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death (	Check only on			
> =	Physic this ce al direc	To E	1 Yes 2 No	Hospital: 1 ☐ Inpatie			and the second	4 LI NU	irsing Home	e 5 ☐ Aeside	ence 6 🗆 O	ther (Speci	fy)
n o	tending Physicien: The leath. tor: After this certificate hithe funeral director, page		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	/	8c. Injury Work		1	d. Describe ho	ow injury occi	urred	
Sio	ttend death tor: /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Inc. At home form	M street factor		Yes 2□		f Location (St	treet and Nun	nher or Pur	al Route Number.
Division of VItal Records,	= 9 = 6	Certification:	4 ☐ Homicide determined	building, etc	iry - At home, farm, c. (Specify)	street, ractory	, onice		20	City or Town		nber or nur	ar noute Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical C		ysician: To the best of	examination and/or								
	o the ithin 2 o the emple	Med	29b. Signature and title of certifier	and manner sta	100.	290	. License	nu <i>m</i> ber		2	9d. Date sign	ned (Month,	Day, Year)
	F 3 F 8		Michael	1. Mula	1 26	)	0	410	67		3 . 2	27.0	7
	• 1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ						12		
ņs.	12		Michael M	Corneck	6(11	M	edro	rel 1	Canja	0 14	Esers	town	MO.
	Sta		31. Date filed (MAIPRY, 0-2 20	07	r's Signature				,				
	Regist	rar			9'								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Julia Elizabeth Misterka Maril 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Butal Baltimore Rathimore Has sincu If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 13 F Director 21 1922 222-12-0547 84 Mar Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo MD Carroll Finksburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be ι 21048 USA 3400 Edolin Farms Ct death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ₩ Widowed 4 Divorced Year or Dates: White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maude (unknown) Charles L. Jester ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400 Edolin Farms Ct. Finksburg, MD21048 item 27 Patricia Preller/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 3/20/2007 permit. Pages I Department of I Important: If Ite any Injury or ot Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem Gardens Middle River, MD Signature of Funeral Service Licensee Pritts Adrineral Home and Chapel, P.A. 412 Washington Road Westminster, MD21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 meg ganial days resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy performed? Yes 2 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1No 1 1npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after in Funeral Direct 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MZL RES-000 MARCH 18,2007 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave. Baltimore, MD 21215

Registrar

31. Date filed (Month, Day, Year)

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TO T

Hospital

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Simal

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Vear Albert J. Machin 8 hrs 2007 11 /Medical Oh 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 25, 213-28-8687 76 1930 Mar MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rthan "natural", or iteme 23a or 28a-f ehov the Medical Exeminer must be notified at Directo 1 ☐ Yes 2 ☐ No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 586 Center Drive 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2X Married 21215-0036 White 1 ☐ Yes 2 No Specify \$ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Person Sporting Goods permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumant. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isaac Winfield Machin Ellen Joan Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Mary Machin/Wife 586 Center Drive, Severna Park, MD Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mar. 15, Glen Haven Memorial 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 2007 21. Signature of Fundam Service Barranco & Sons, P.A. Severna Park Funeral Home 21146 495 Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lah Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit death certificate be executed tenosla ortre Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an has page certificete 1 Yes of Vital 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**∑** No ē ٩ 1 Tyes 1 K Inpatient 2 ER/Outpatient 3□ DOA this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide ö To the Hospital within 24 hours a To the Funeral D filled Hospital TÉ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) Jan as 4659 3 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) conter Hospital dive

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State

Registrar

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31. Date filed (Month, Day, Year)

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32. Register's Signature

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death (Item 23a) (

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			1 - State of Marylar	•	rtment of H		F	leg. No.	7 10369
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Rafael I. Ruiz  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		h	13, 2007  4c. County of Dea	ath
	Funeral Director		Beverly Living Center of Volume 5. Social Security Number 6. Sex 7. Age (In yrs. 580-20-7451 12 M 2 F 84		If Under 1 Year Months Days	Westmi If Under 24 Hrs. Hours Min			nthplace (State or Foreign ountry)
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or frems 23s or 28s-1 show other transmitted in Madical Examinations is notified at	Funeral Director	10a. State 10b. County 10c. Ci  MD Carroll Ha  10e. Street and Number 845 South Main Street  11. Marital Status 12. Was Decedent Ever in Uarmed Forces?	ty, Town or Locamps te	ad 10f. Zip Code	074 spanic Origin? (S		U.S.A.  14. Race - Am Black, Wh	erican Indian,
21212-0030	e filed within 72 hours afte al Hygiene. I other than "naturel", or It vent, the Medical Examin	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced  1 Yes 2 No If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decede (Give k life. D	Yes 2 No  ent's Usual Occupa und of work done a o NOT use retired, -Employ	Specify: Pue ation furing most of wor ed	erto Ric	can <sup>Specify:</sup> Wh 16b. Kind of Business Construc	nite s/Industry
<u> </u>	2 should be till n and Mental Hi le marked oth raumatic even	To Be	17. Father's Name (First, Middle, Last)  Manuel Iglesias  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street a	Fran	ncisca	Maiden Sumame) Ruiz r, City or Town, State,	Zip Code)
ore, Ma	ages 1 end 2 nt of Health a :: If Item 27 le r or other trau		I Li bunar 2 El Cremation 3 Linemova non 3tate 1	Place of Dispos cemetery, crem.	Box 53 sition (Name of atory or other place	9) 3/17	7/2007	D 21102 20c. Location - City o Winfield	
Baltimor	permit. Pages 1 en Department of Heat Important: If Item 2 any injury or other once.		21. Signatury of Funeral Service Licensee  MO04	43 M 9		s of Facility rboraw s St.	Funera Westmi	l Home nster, MI	
	Certificate be executed duing physicien and duing physicien and tase as the burial-transit	ilcai Examiner	23a. Part. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, havy, leading to himsediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions of the conditi	quence of):		j, such as cardiac	correspiratory arr	est,	Approximate Interval Between Onset and Death  6 MONTHS
O. DOX O	certific Iding p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	oldeath 3 ⊟8	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
oras, r.	w requires that the de been signsd by the should be detached	۾	Part II. Other significant conditions contributing to death but not res	ulting in the und	derlying cause give	n in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
iai nec	n: The faw r ficete hes be or, page 2 sh	e Completed	25. Was case referred to medical					med? prior to death? 2 No 1 □ Ye	utopsy findings available completion of cause of s 2 No
STOLIO LOS	To the Hospital or Attending Phyalcian: The law requires that the death within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for usompletely filled in by the funeral director, page 2.	Certification: To Be	examiner?  1  Yes No Hospital: 1 Inpatient 2   27. Manner of Death Natural 5 Pending 2 Accident investigation 3  Suicide 6 Could not be	28b. Time of Injury	28c. Injury Work M 1 \( \text{Y}	Nursing H	28d. Describe he	ence 6  Other (Spectow injury occurred	
2	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide  determined  256. Place of Injury - Art in building, etc. (Specifical Check only 2 Medical Examiner: On the basis of examinary in the bas	(y)	occurred at the tim	e, date and place	City or Town	n, State)	s stated
	To the H within 24 To the F complete	Medical	29b. Signature and fille of sertifier	morrandormye	29c. License		2	9d. Date signed (Mon	th, Day, Year)
	N.35		30. Name and address of person who completed cause of death (Iter	AGAN	Print)		i		R MD 21159
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 9 2007	iture	Socile				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item #31 State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 3/23/07 per VR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Charles J. Supernavage 2007 8:55 A 21 March /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington 8. Date of Birth (Month, Day, Year) May 18, 1921 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 85 Pennsylvania Maÿ 168-14-5734 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at 1XTYes 2 No Director Maryland items 23a or 28a-f <u>Washington</u> Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with a Department of Health and Mental Hygiene. Important: If them 27 is marked other than "--- any injury or other traumatts." Funeral 82 Sunbrook Lane 21742 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Supervisor</u> Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Supernavage Isabella Shabonis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Supernavage - Wife 82 Sunbrook Lane Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify awnside Cemetery Mar.24,2007 Pilesgrove, New Jersey 21. Signature of Funeral Sen OSBOTTE TURE FAILTHOME, P.A. 425 S. Conococheague St. Williamsport, Maryland Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or horit failure. List only one cause in each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Tyes after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Division or Vital Records, P.O. Box 68760

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State Registrar 29b. Signato

30. Name and address of pe

31. Date filed (Month,

Mar.22,200

DHMH 17 Rev 1/2001

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29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March March **Physician** 2007 Margaret Jane Swain 16:17 PM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Maugansville 13825 Maugansville Road
5. Social Security Number 6. Sex 8. Date of Birth (Month, Day . Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2XF Months 75 Maryland 214-28-5993 Yrs Director Usual Residence of Decedent 27. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28e-f show ital Hygiene. Id other than "natural", or iteme 23a or 28e-f shov event, the Medical Examinar must be notified at Maugansville Maryland Washington 1 TYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21767 13825 Maugansville Road U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Slatus z. v. 2 should be filed within 72 hours after design and Mental Hygiene.
77 te marked other \*\*-1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: If Yes, Give Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame)
Vernie Coffman Baker 17. Father's Name (First, Middle, Last) Be Jesse Newton Baker permit. Pages 1 and 2 should be Department of Heelth and Menta Important: If Item 27 1s marked eny injury or other treumatic evones. ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13825 Maugansville Rd. Maugansville Maryland 21767 Alfred Eugene Swain (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 3-21-07 Hagerstown Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician stast months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical the IF FEMALE: If yes, oulcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the ch ል bete hes been signed page 2 should be det Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 🕅 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural s after decret After by the fu 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, elc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral I Hospital 29a. Certifier 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 05H-5 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 21 2007 Registrar

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	1 - State	State	of Maryland		rtment of I tificate of		ııu ivlen		- 0 0	(m) mg	1000
	Registrar  1. Decedent's Name (First, Midd	dle Last)		Cert	illicate of	Dealii	2. [	Reg Date of Death	g. No.	UT	3. Time of Death
1		· .	Jarret	Slave	sman			MARCH	Day	Year 2007	5:00 P
	4a. Facility Name (If not instituti	on, give street and r	number)	Ī	4b. City, Town,				4c. County	of Death	imore
-2	5. <b>220-12-6883</b>	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. las	t birthday)_ Yrs.	if Under 1 Year Months Days		June	Date of Birth Month, Day,	<sup>Year)</sup> 1923	9. Birthpla County Balt	ace (State or Foreign).
	Usual Residence of Decedent  10a. State 10b. Count	ty	10c. City, 1	Fown or Loc	ation					10	d. Inside City Limi
חוופרוחו		roll		nksbı	urg			10	g. Citizen of V	What Count	1 □ Yes 2 🕍 N
	133 Lassit	er Circ	le		2104	18			U.S.		•
,	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorce	Armed 1 1 1 Yes	ecedent Ever in U.S. Forces? s 2 ☐ No W • W Give Dates:	13. W	/as Decedent of l Yes, specify Cub ☐ Yes 2☐ <b>X</b> 0o		gin? (Specify , Puerto Rica	Yes or No- n, etc.)		e - America ck, White, e /: Whi	tc.
	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education		16a. Decede (Give k life. D	ent's Usual Occu ind of work done O NOT use retire	ipation e during most ed)	of working		6b. Kind of Bu		•
nandilloo	12	+:		Mecl	nanical	1		.1			Steel
	17. Father's Name (First, Middle Clare		egrove S	laysr	man		,	Leoi	nard	ne)	
	19a. Informant's Name/Relation B. Marie Sl				Address (Stree Lassit						
	20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal froi ( <i>Specify</i> )	m State South	e of Dispos netery, crem Carı	ition (Name of patory or other place ${ t cl}$	emato	3/19 <sup>Date</sup> ory	2007 2	Oc. Location -	-	
	21. Signature of Funeral Service	e Licensee	_M01	1 9 1 22.	Name and Addr	ess of Facility	<b>y</b>	ınera	l Home		
1	23a. Par 1. Enter the disease, sb ck, or heart failure. Li	or complications tha	t caused the death.		91_Will	lis-St		estmi	nster.	, MD	21157
		st only one cause or		DO HOL EITE	tine mode of dy	ring, such as	cardiac or res	spiratory arres	St.		Approximate
	Immediate Cause (Final						cardiac or res	spiratory arres	St,		interval Between Onset and Death
	disease or condition resulting in death)	a. CC	n each line.  INGESTIVE to (or as a consequer	HEA			cardiac or res	spiratory arres	St,		Interval Between
	disease or condition resulting in death)	a. CC Due t	INGESTIVE to (or as a consequer DRONARY &	HEA	RT FAI	LURE	cardiac or res	spiratory arres	st,		Interval Between
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edical Certification: To be Completed by Physician/Medical I	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. CC Due t b. CC Due t c. Due t d. 23c. If yes, of the policy of the po	DNGESTIVE to (or as a consequent to (or as a	HEAnce of):  RTER nce of):  PRTER nce of):  Py eath 3   th 5    R/Outpatient 8b. Time of Injury e, farm, stree edge, death n and/or inv	Ectopic pregnant Other (specify)  derlying cause give  3 DOA Ot 28c. Inju Wc 1 Coccurred at the estigation, in my 29c. Licen	cy  26. Place ther: 4 Nu ury at ork? Yes 2 1	of Death (Chrsing Home 28d. No 28f. I	23e. Did tobs  1  Yes  24a. Was an autopsy perform  1  Yes  5  Resider  Describe how  Location (Stre. City or Town, due to the cat it the time, da	23d. Da Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo	te of deliver onth []  stribute to the stribute to the stribute to onth stribute to the stribu	y Oay Year e cause of death? ably 4 Unknow sy findings availat ppletion of cause of 2 No  Route Number, ated. the cause(s)
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# Ammend #7 per F.D. WSH 3/20/07 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland /		tment of H		nd Mental H	/giene Reg. Nø	007	10373
	Physic	ian	1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi		Robert Lynn Saue						3	15	2007	10:15 P. <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give				b. City, Town, or		Death	1	County of Death	
_7100		-	Long View Nursin  5. Social Security Number 6.5	-	e (In yrs. last b		Manchest	er If Under 2	4 Hrs. I 8 Date of B		arroll	place (State or Foreign
Ŀ	Funeral Director		212–14–8283 Usual Residence of Decedent	Sex 7. Aga	79		nonths Days	Hours	4 Hrs. 8. Date of B (Month, D 12/22/	ay, Year) 1917	Mary	ntry)
	yland now at		10a. State 10b. County		10c. City, Tov	wn or Locati	ion				- 1	10d. Inside City Limits
	a-fsh ified	cto	MD Carroll		Hampst	ead						1 ∐Yes 2X No
	ith the or 28 e not	)ire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	ath w 23a ust b	a	4600 Lynncrest Dr	ive			21074			Unite	ed State	s
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sdical Examiner must be notifiled at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 12 Yes 2 N If Yes, Give Year or Dates:	4040	_ ا ک	s Decedent of His es, specify Cubar Yes 🏋 No	spanic Origi n, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		4. Race - America Black, White, Specify:	
5-0036	2 hou latura ical E	ted	15. Decedent's E	L ducation	16a	a. Deceden	t's Usual Occupa	ition		16b. Kin	d of Business/In	dustry
215	hin 7 e. an "n Medi	ble	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give kind life. DO	d of work done d NOT use retired)	uring most (	of working			
2	filed within Hygiene. Ither than "	Completed	12			uperv	visor			Rail	road	
	be file	Be	17. Father's Name (First, Middle, Last						s Name (First, Middle	•	Surname)	
√a	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the Me	မ	Luther C. Sauerh						Mae Macke			
, Maryland	r 2 and		19a. Informant's Name/Relationship ( Audrey Sauerhamm						or Rural Route Num ve Hampste			
Baltimore,	Pages 1 ament of Heamant: If item		20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		20b. Place of cemeter Hamps	of Disposition ery, cremate CEAC	on (Name of ory or other place Cemeter	y 3,	Date /19/2007	l	eation - City or To ostead, 1	own, State Maryland
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licer	Eline	M00723	2	ame and Address		Eline Fun			4 South
8760,	Physician and whisician and the buriar-transit	lical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a b.  Cue to (or as a c.)  Due to (or as a c.)	a constituence	ot):	e de	men	tia -c	lezha	unela	Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal deatl		topic pregnancy her (specify)			23	3d. Date of delive	ery Day Year
	res that igned by be deta	by Ph	Part II. Other significant conditions	ontributing to death bu	t nat resulting i	in the under	rlying cause giver	n in Part I.	23e. Did	tobacco us	e contribute to the	he cause of death?
ğ	w require been sig should b		seizur	e disor	der				1□	Yes 2	No 3□ Prob	oably 4 □Unknown
Vital Records,	has bed ye 2 sho	Completed	PV	D .					24a. Was		24b. Were auto	psy findings available mpletion of cause of
<u> </u>		Sorr								ormed?	death?	2 □ No
/ita	certifica ector, p	Be (	25. Was case referred to medical examiner?						f Death (Check only	one)		
OF	hysi this c	은	1 ☐ Yes 21 No	Hospital: 1 ☐ Inpatier				4 AU Nurs	ing Home 5 ☐ Res	idence 6	☐Other (Specif	y)
n E	iding Physician: h. After this certifica funeral director, p	on:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injury Work?		28d. Describe	how injury	occurred	
Division	I or Attending Physician: after death. I Director: After this certifica d in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, fa (Specify)	_		es 2 □ No	28f. Location	Street and wn, State)	Number or Rura	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	one)	ysician: To the best on the basis of and manner state	examination ar	e, death oc nd/or invest	tigation, in my op	inion, death	place, and due to the occurred at the time	cause(s) a , date and p	and manner as si place, and due to	tated. the cause(s)
	10/		29b. Signature and title of certifier  Vivcie 4	Ryber	g,D.	0.		number 9612		3/	signed (Month,	Day, Year)
	Mary			Handvel	Pike	1 7	Nanch	ie	L. RYD	z)	102.	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 1 9	32. Registra	r's Signature	1	ريم					

DHMH 17 Rev 1/2001

ORIGINAL

# Amended Item 29d per Physician 03/16/2007 Carroll County, wil

menaca	Please T	ype o	r Print	in Black	Indelible	Ink. Ensu	re All	Copies	Are	Legibl	ę
										/ 11 11	

			For State Registrar	State of Ma	iryianu	•	tificate of L			eg. No.	, ,	10017
	Physici	20	1. Decedent's Name (First, Middle, Last)						2. Date of Deal	th Day	Year	3. Time of Death
	Physici /Medio		Thomas Josep						March	14, 20	007	9:15 a M
	Examin	er	4a. Facility Name (If not institution, give s Carroll Lutheran V					Location of Death		4c. Cour	nty of Death Carro	11
	Funeral Director		217-12-7225	7. Age	(In yrs. lasi 84	t birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Aug 23,	Year)	9. Birthp Cour <b>Mar</b>	place (State or Foreign otry) yland
	land bw ft		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	cation				1	Od. Inside City Limits
	a-f sh	ctor	Maryland Baltimo	re			St	evenson				1 ☐ Yes 2 No
	th with the 23a or 28	ai Dire	10e. Street and Number 10613 Stevenson Ro	ad			10f. Zip Code	21153	1	0g. Citizen o	of What Cour JSA	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantics rintal terrorities and once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 □ N If Yes, Give Year or Dates:	0		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 万No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, city: W	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grade		1	(Give	lent's Usual Occupa	during most of work	ing	16b. Kind of		
21215-0036	within ene. than '	ompi	Elementary/Secondary (0-12)	College (1-4or 5-	+)		00 NOT use retired Accountar				and El Compan	ectric v
2 pc	e filed II Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	4	L			18. Mother's Nam	e (First, Middle, I			4
ylar	ould by Menta	ToE	John Schussler					Mary 1				
Maryland	d 2 sh th and th and 17 is m traum		19a. Informant's Name/Relationship (Type Dorothy Schussler		î		-	and Number or Run on Road,				
	ages 1 an nt of Heal : If item 2		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	•	20b. Plac	e of Dispo	sition (Name of natory or other place		Date	20c. Location	n - City or To	own, State
Baltimore,	permit. Pa Departme Important any injury once.		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	<sup>99</sup> МО11	1	22	. Name and Addres	ss of Facility M	yers-Dur	boraw		al Home
	403 e 0	-	23a. Part . Enter the disease, or compli	ications that caused	کب the death. ا			g, such as cardiac			MD 21	Approximate
	Pnysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Athero:	scien		Cartiova	uscintar	Divec	ric		Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a	consequen	108 01):						
	led nsit	niner	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	CONSEQUEN	tou of)r						
60,	rtificate be executed ng physician and as the burial-transit	Aedicai Examiner	that initiated events resulting in death) Last	Due to (or as a	ı consequen	nce of):						
68760,	ficate g physics as the	edica		d								
.O. Box	death cer e attendir ed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 1 9 Unknown	2 ☐ Fetal de	ath 3	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
s, D	luires that the de n signed by the a ild be detached f	by	Part II. Other significant conditions cor	ntributing to death bu	t not resultir	ng in the ur	nderlying cause give	en in Part I.		bacco use co		ne cause of death?
Record	The law requires that the rate has been signed by the page 2 should be detache	Completed							24a. Was a autops perform	y	prior to co death?	psy findings available mpletion of cause of
Vital		BeC	25. Was case referred to medical examiner?					26. Place of Deat				
of	Phys rthis raldii	P.	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	lospital: 1 🗌 Inpatier 28a. Date of Injun (Month, Day	y 28	VOutpatien Bb. Time of Injury	28c. Injury Work	4 Enursing Ho	ome 5 Reside 28d. Describe ho			(y)
Division	al or Attending ; after death. I Director: After d in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home . (Specify)	e, farm, stre			28f. Location (SI City or Town	treet and Nui n, State)	mber or Rura	al Route Number,
	e Hospital or 124 hours afte e Funeral Dir letely filled in	Medical C	29a. Certifier (Check only one)  Certifying Physical Cartifying Ph	sician: To the best of ner: On the basis of and manner stat	examination							
	To the within 2 To the complex	Me	29b. Signature and title of certifier				29c. License	e number	2	9d. Date sign	ned (Month,	A.
}	WILLA		30. Name and address of person who co	moleted cause of do	eath /Itom 23	3a) (Typa	Print)	3725	•	311	4100	<del>5-</del> 03/14/07
	5110		TARIO MALTMO	OD 19			und V	Vestmir	ster	MD	2113	7.
	Sta Registr	-	31. Date filed (Month, Day, Year)  MAR 1 6 2	32. Registra	r's Signatur	·	Card V					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16, 2007 ear **Physician** March 3:10 A M PAUL MERRITT SETZER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months 1943 OKLA. 63 567-68-7919 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location fshow 10a. State 10d. Inside City Limits r 28a-f shov notified at 1x Yes 2 □ No Director MD Frederick Middletown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 16 Young Branch Dr. 21769 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) illustrator art 7 is marked other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Juanita Ruth Adams Paul M. Setzer Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Young Branch Dr., Middletown, MD 21769 Kathleen Setzer (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Diaposition 20c. Location - City or Town, State 1 ☐ Burial /2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory3/17/07 Smithsburg, MD 4 ☐ Doration 5 ☐ Other (Specify) re of H Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Art : Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer **Physician** Mon ths /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 No 1∐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Medical Certification: 5 ☐ Pending investigation Hospital or Attending (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No thours after death.

-uneral Director: A
ely filled in by the fu death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours
the Funeral Directory filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) vithin 2s. and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 16,2007 Fauzi Rizvi, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th Street Frederick . M 21701 400 West MAR 2 0 2007 Registrar

			For State Registrar	St	ate o	f Mary	/land /		artmen rtificate				ental Hyg	iene <sub>eg. No</sub> 2 ()	07	10376
I	Physicia	an	1. Decedent's Name (First, Middle, William	_	Tans	i11,	Tr.						2. Date of Deat Month March 1		Year	3. Time of Death 10:00 P M
	/Medic	1	4a. Facility Name (If not institution,				01.		4b. City,	Town, or	Location of	of Death	1102011	4c. Count		
	LAdillii	-1	National Luth						F	lockv	ille			Mo	ntgo	omery
	Funeral Director		215-03-0250	6. Sex 1 🖾 M	2□ F	7. Age (II 8	n yrs. last i 8	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Dec • 4, ]	1918	9. Bin Co Ma	thplace (State or Foreign ountry) aryland
	and	1	Usual Residence of Decedent  10a. State 10b. County			10	Oc. City, To	own or Lo	cation							10d. Inside City Limits
	Mary I eho	ţō	Md. Montgo	mery				Rock	cville	2						1X Yes 2 □ No
	or 28s	Director	10e. Street and Number						10f. Zip				1	0g. Citizen ol		ountry?
	ath wi	ral	9701 Veirs Dri					1.0		2085				US		
	items	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	A	rmed Fo		r in U.S. 1942 –	13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexicar	gin? (Spen, Puerto	ecify Yes or No- Rican, etc.)		ack, Whit	erican Indian, te, etc.
936	ours af		3 Midowed 4 Divorced	11	Yes, Giv ear or D	re ·	1946		1 🗆 Yes	2 <b>⊠</b> No	Specify:			Spec	ify: Wh	nite
2-0	72 hc	eted	15. Decedent's (Specify only highest				16	6a. Dece (Give	dent's Usua kind of wo DO NOT us	l Occupa k done d	ition furing mos	t of worki	ing	16b. Kind of	Business	/Industry
121	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23e or 28e-f ehow ent, the Mudical Evantiner meating or relitted at	Completed	Elementary/Secondary (0-12)	C	coltege (1	-4or 5+)		IITO.	Bake		,			US	Gos	vernment
<b>Q</b>	illed Hygi other	0	17. Father's Name (First, Middle, L	ast)									(First, Middle,		me)	
Maryland 21215-0036	Menta Menta mrked mric ev	To B	William B. Tans	i11,	Sr.			_			Ka	ther	ine Mito	chell		
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationsh William B. Tans			lon	1						a <i>l Rout</i> e Number s Church			
Ę,	Heelt Heelt tem 2		20a. Method of Disposition	111,1	. 1 1 / L		20b. Place		osition (Nari matory or o				-	20c. Location		
ē	Pages lent of nt: If i		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		val from	State			matory or o Eort (			ar.1	7,07	Alexa	ndria	a, Va.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Imperiant: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the hydical Exercities must be rediffied at once.		21. Signature of Funeral Service &	idensee	1	7							ol Funer			DC 20007
	.5		23a. Part . Enter the disease, or o shock, or heart lailure. List of	complicationly one ca	ons that o	aused the	e leath. D	o not en	ter the mod	e ol dyini	g, such as	cardia,	or respiratory arr	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a.	5	nal	1 57	tag	201	20	me	X,	9			mset and Death
-	/Medical Examiner		resulting in death)		Du <sub>0</sub> N	or as a c	onsequenc	ce of								M. m. Yal
<u>#</u> .		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to	(or as a c	onsequenc	ca of):			1	) ,	1			menths
	cuted nd transit	Examiner	that initiated events	c		ine	2051	live	he	ant	L R	w	lene			months
8760,	cate be executed physician and the burial-transit	cal Ex	resulting in death) Last		Due to	(or as a/c	onsequeño	ce of):								
687	ficate physis ts the	edica		d							V					
Вох	death certific e attending pl id for use as t	M/UE	IF FEMALE: 23b. Was decedent pregnant				pregnancy Fetal dea		⊒Ectopic pi	ennancy					Date of de	
P.O. B	that the death ted by the atter detached for t	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nant at tim	ne of death		Other (sp					, n	Month	Day Year
	8 50	ρ	Part II. Other significant conditio	ns contribu	uting to d	eath but r	not resulting	g in the	in erlying o	ec-P	en in Part	1.	23e. Did to 1 ☐ Y	. /	-	to the cause of death?  Probably 4 ©Unknown
Records,	w requires been sistemand I	Completed	Atial	//	1. h.	-1//	with		,				24a. Was a		o. Were a	autopsy lindings available
Be	The lay	mo:	1100100	1/	11/-	-/-		/		-			autop perfor	rmed?	prior to death? 1 \square Ye	
/ita	cian: ertifice actor, p	Be C	25. Was case referred to medical examiner?									e of Deat	h (Check only or			
of\	Physician: r this certific ral director,	. To	1 Yes 2 No	Hosp	1 🗆	Inpatient of Injury		Outpatie			4 (1)	ursing Ho	ome 5 Resid		<u>-</u>	ecify)
ou	Attending r death. ector: After	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	9	(Mor	of Injury th, Day Y	'ear)	Injury	м	28c. Injun Worl 1 □	k? Yes 2.⊑	]No		,,		
Division of Vital	il or Attend after death I Director: A	Certification:	3 Suicide 6 Could n 4 Homicide determi		8e. Place build	of Injury ing, etc. (	- At home (Specify)	, farm, st	reet, factor	y, office			281. Location (S City or Tow		nber or F	Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C		Examiner:	On the b		kamination						and due to the or			as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	0	1	1			29	c. Licens	e number			29d Date sign	ned (Mor	nth, Day, Year)
•	2		1 Cal	el	W.	Ker	reet		7	1) 7	117	26		Man	ch	14,2007
×			30. Name and address of person of Charles W. Ka							. Dat	กลระบ	s. M	d. 2087	2-1848		
	Sta Regist		31. Date liled (Month, Day, Year)		32. F		s Signature	Э	Cook.				w. 20072	2 1040		
400		100	111111 25			W. 375	day, oh (7)	1000	350000000000000000000000000000000000000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 16, Day 2007 Year **Physician** Leroy Thomas 8:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sligo Creek Nursing Home Takoma Park 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 6, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1√ M 2□ F T917 89 Director 579-14-9160 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 No Directo MD Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5432 Whitfield Chapel Road 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Black 2 3 Widowed 4 Divorced "natural". permit. Pages 1 and 2 should be filed within 72 hc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical gonce. Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Machinist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John S. Thomas Magie Landsdown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Thomas, Jr./son 5432 Whitfield Chapel Rd. Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/17/07 Beltsville, MD Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical signed by the attending p d be detached for use as IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 21 No 1 ☐ Yes 2 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20/40 Hospital: Certification: To 1 Tes 1 | Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Magner of De th 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) AKOMA PARK, MD 20912 30. Name and address of person v of death (ftem 23a) (Type, Print) r5109

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

Day, Year)

20

MAR

07-02208 Zong Yuan Tano Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certifical Registrar	te of Death	Reg. No. 400/	13
Physici al Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day March 22, 2007  3. Time of Deat Year 1506 hrs	
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		
		640 Santa Maria Lane	Davidsonville	Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthout 1	Months Days Hours Mi Yrs. If Under 1 Year If Under 24H Months Days Hours Mi	<b>—</b>	
any		10a. State 10b. County 10c. City, Town or	Location	10d. Inside Cit	ty Limits
Maryland 28a-f show 1 at once.	5	Maryland Anne Arundel Davidson	ville	1 Yes 2	X N
Maryl r 28a-i ed at o	rector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
ith the Mi 23a or 2 notified	al Di	638 Santa Maria Lane  11. Marital Status  12. Was Decedent Ever in U.S.	21035	USA	
eath w items ust be	Funeral	1 Never Married 2 X Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? ( § If Yes, specify Cuban, Mexican, Puerl</li> </ol>		CK,
led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	by Fu	3 Widowed 4 Divorced or Dates:	1 Yes 2 No specify:	Specify: Asian	
hours a		15. Decedent's Education (Specify only highest grade completed) 16a. De	ecedent's Usual Occupation (Give kind of ring most of working life. DO NOT use re	work done 16b. Kind of Business/Industry	
permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)			
d with ygiene ther t	l o	17. Father's Name (First, Middle, Last)	ineer 18. Mother's Nan	Mechanical Engine (First, Middle, Maiden Surname)	eer
be file ntal H rked o	Be (	Da Yan Tang	Wen Shu	Cheng	
hould nd Me is ma atic ev	욘		- ,	Rural Route Number, City or Town, State, Zip Code)	
and 2 s ealth a em 27 raum:			8 Santa Maria Lane Disposition (Name of cemetery,	Davidsonville, MD 21035  Date   20c. Location - City or Town, State	
permit Pages I ar Department of Hea Important: If ite injury or other tr		1 Burial 2 X Cremation 3 Removal from State cremator	y or other place)		
nit Pa artmen ortani		4 Donation 5 Other Specify: Huntt 21. Signature of Funeral Service Licensee		/27/2007 Waldorf, MD ert E. Evans Funeral Home	
Dep.		Keith Sypolt (per DVR)		oad Bowie, MD 20715	
ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Between Ons	
Medical xaminer	1	Immediate Cause (Final disease a. Drowning complicating)	hypertensive atheroscle	erotic cardiovascular Death	h
		b But to (or as a consequence or).	NA.		
	Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
	amin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last			
cuted nd transit	Exa	d			
oe exec ician a irial - 1	Medical	X UNPENDED X AMENDED perFD, 23a,27,2	28a-f. perME. g866.4/30	D/07 TT	
e death certificate be executed the attending physician and ed for use as the burial - transit	/We	23b. Was decedent pregnant in the		23d. Date of delivery	'ear
h certii tending use as	Physician/	past 12 months?  4 Pregnant at time of death	Fetal death 3 Ectopic pregr Other (Specify)	Month Day re	Gai
the atted for	hys	1 Yes 2 No 9 Unknown 9 Unknown			
ires that the signed by t I be detache	by P	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deal	
requires been sign				24a. Was an   24b. Were autopsy findings a	05-11
tal or Attending Physician: The law require rs after death  al Director: After this certificate has been si led in by the funeral director, page 2 should b	Completed			autopsy prior to completion of car performed? death?	
ician: The certificate rector, page		25. Was case referred to medical	26.Place of Death (Checi	1 Yes 2 No 1 Yes 2	No
hysician this cert il directo	o Be	examiner?		ing Home 5 Residence 6 ✔ Other: Scene	
ling Phy After th funeral			me of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
tendin leath tor: A	atio	Natural = -	2:50 pm 1 Yes 2 X No	subject drowned	
al or At s after d al Direc ed in by	Certification:	3 Suicide 6 Could not be determined (Specify) others scope	n, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Numb or Town, State) 640 Santa Maria Lane Davidsonvi	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Ce	29a. Certifier (Check only one)  2 ✓ Medical Examiner: On the basis of examination and/or inv		nd due to the cause(s) and manner as stated.	
To wit	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
		Talinot ACI	O.C.M.E.	March 23, 2007	
		30. Name and address of person who completed cause of death (Item 23a)			
			Penn Street, Baltimore, MD 2	1201	
		31. Date filed (Month, Day, Year) 32. Refistrar's Signature			
S Regis	tate trar	MAR 2 7 2007	bode		

43-61-6/1 mild c Karling #21

Director

Director

1. Decedent's Name (First, Middle, Last)

1104 CIRCLE DRIVE

5. Social Security Number

10e. Street and Number

WV

235-32-0785

Usual Residence of Decedent

Glen Earl Unger

4a. Facility Name (If not institution, give street and number)

Ravenwood Lutheran Village

6. Sex

BERKELEY

**X**XM 2□ F

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

/Medical **Examiner** 

Division or Vital Records, P.O. Box 68760, funeral director,

Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. XXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes XIX No Specify WHITE Specify Š ¾[X] Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HOROLOGY Elementary/Secondary (0-12) College (1-4or 5+) WATCHMAKER/ JEWELER (HOROLOGIST) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EARL UNGER METHA LEE STOTTLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2312 N. VAN BUREN CT., ARLINGTON, VA 22205 SHANNON L. KESECKER/DAUGHTER MARCH Date 20b. Place of Disposition (Name of PLEAS ANY Crepatory or other place)
MEMORY GARDENS 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 27, 2007 MARTINSBURG, WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) suraten Moulu r as a consequence of nemone Wech Sequentially list conditions, (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician for use as the burla Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 **J** No 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nell flied - Hagstein 0902040 AR SH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death

4b. City, Town, or Location of Death

Hours

Hagerstown If Under 1 Year | If Under 24 Hrs.

Days

MARTINSBURG

10f. Zip Code

25401

7. Age (In yrs. last birthday,

10c. City, Town or Location

82

2. Date of Death

March

8. Date of Birth (Month, Day, Year) 12/21/1924

Month

Day

24,

Year

Washington

10:48A

10d. Inside City Limits XXYes 2□No

9. Birthplace (State or Foreign

WEST VIRGINIA

2007

4c. County of Death

10g. Citizen of What Country?

USA

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 0400 M 2007 15 /Medical 4c. County of Death acility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 280 Hillsmere Drive Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 80 215-22-3941 Yrs. 1926 Maryland Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2XXIIo with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or 21403 280 Hillsmere Drive U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a rry or other traumatic event, the Mectical Examiner must 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. 1XX es 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1944-46 1 ☐ Yes 2XXXNo ģ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Manager Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur H. Valentine Mildred Booth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Valentine/son 1509 Hickory Wood Drive Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Ite any Injury or o **™**Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Vets. Cemetery 3/19/2007 Crownsville, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consed The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No been signed by the a 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has b autopsy performed? 1□ Yes 2□No To the Hospital or Attending Physician; director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death to the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of contier 29c. License number 29d. Date signed (Month, Day, Year) Chief Medical Officer of the Chesapeake

13

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. LaPenta, MD 445 Defense Highway, Annapolis, MD 21401 32. Registra's Signature 31. Date filed (Month, Day, Year) MAR 1 6 2007 ▶ 2

D 21438

	1	For State Registrar	State of Maryla	•	artment of rtificate o			giene 0 0	7 1038
Physiciar /Medica	1	1. Decedent's Name (First, Middle, Last)  Robert Et	ıgene \	Vilson			2. Date of Dea Mar 24,	2007	3. Time of Death 1:03pm
Examine	•	4a. Facility Name (If not institution, give s Devlin Manor Nursi			4b. City, Town	n, or Location of Dec erland	ath	4c. County of Allegar	
Funeral Director		210-12-3131	7. Age (In your 84	rs. last birthday) Yrs.	If Under 1 Ye Months Day			, 1922 S	D. Birthplace (State or Foreig
ahow ed at	Ī	Usual Residence of Decedent  10a. State 10b. County  MD Allegan		City, Town or Lo	ocation Derland				10d. Inside City Limit
be notifi	2	10e. Street and Number			10f. Zip Cod	21502	1	10g. Citizen of Wh	
Department of Health and Mental Hygiene "natural, or Itama 23a or 28a-f ahow Important: If Itam 27 is marked other than "natural, or Itama 27 is marked other any Injury or other traumatic avant, Ita Madical Examinar must be notified at once."  To Be Completed by Filmeral Director	2	220 Somerville Ave  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: WW		Was Decedent of Yes, specify C	of Hispanic Origin? Suban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.
tal Hygiene. d other than "natural", or Itama 23a or 28a-f ahow avent, tra Modical Examinar must be notified at Be Commission by European Directors	Complete	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	dent's Usual Oc kind of work do DO NOT use rel ruction V	ne during most of w tired)	1	16b. Kind of Busi	ness/Industry
mental Hy arkad oth atic avant	0	17. Father's Name (First, Middle, Last) George Wilson					ame (First, Middle, (Wentlin		
27 is ma	1	19a. Informant's Name/Relationship (Ty. Judy Rodgers	daughte	r 19b. Mailir	ng Address (Stre 19 Roya	et and Number or I Road	Rural Route Numbe Hager	r, City or Town, Si 'Stown	MD 21742
ent of Hea nt: If Itam ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Oremation 3 ☐ R 4 ☐ Donation _5 ☐ Other (Specify)	14 00	Place of Dispo cemetery, crei carpelli Fu	natory or other i	olace)	Date 3/26/2007	20c. Location - C	
Depertm Importa any Inju onca.		21. Signature Funeral Service Licens	10001	22		eili Funeral	Home, P.A. ue; Cumber	land MD 2	1502
ysician Medical raminer		23a. Part. Enter the disease, or complished to the condition of the condition resulting in death)  Sequentially list conditions.	Due to (or as a cons	equence of):	er the mode of o	dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
physicien and the burial-transit	T Ya	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	Marie of L					
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n signed build be deta	5	Part If, Other significant conditions cor	tributing to death but not i	esulting in the u	nderlying cause	given in Part I.			ute to the cause of death?
pa c							24a. Was a autop: perfor 1 □ Yes	sy pri med? de:	ore autopsy findings availai or to completion of cause of ath? I Yes 2 □ No
his certif	2	1 103 2510		☐ ER/Outpatier	II 3 DOA	Other: 4. → Narsing	eath (Check only or Home 5 Resid	ence 6 Other	1
would be seen of the confliction of the funated birector. After this certific completely filled in by the funeral director.  Modical Certification: To Be of	Cario	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year,		M 1	njury at Work?   Yes 2 No		ow injury occurred	
ral Diract		4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ocify)	eet, factory, offi	ce	28f. Location (S City or Tow		or Rural Route Number,
ha Funal pletely fil	I I	29a. Certifier (Check only one)  1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier P	sicien: To the best of my later: On the basis of exam and manner stated.	nowledge, deat ination and/or in	h occurred at the vestigation, in m	e time, date and pla ny opinion, death oc	ce, and due to the c curred at the time, c	ause(s) and manr late and place, an	ner as stated. d due to the cause(s)
To th comp	- (	29b. Signature and title of captilier	しない		29c. Lice	D17565	ż		Month, Day, Year)
State Registral		30. Name and address of person who contains a second secon		922	•	Highway	LaVale M□	21502	

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	<b>.</b>		1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month	aath Day	Year	3. Time of Death
	Physicia /Medic	_	Margaret	Nebstu	1				03	11	04	9.22 AM
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	Funeral		Social Security Number     6.	Sex 1 □ M 2 <del>∏</del> F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, D	rth ay, Year)	9. Bi	rthplace (State or Foreign ountry)
	Director	. }	220-80-9906	X	87	115.			11/20/	1919_		DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
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	28a-	Director	MD Caroli  10e. Street and Number	ile	T.	edelal	10f. Zip Code			10g. Citiz	zen of What C	country?
	with 3a or		310 Buena Vista	Arronito			21632			US	: Δ	
	ns 2:	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of Hill Yes, specify Cuba	spanic Origin?	(Specify Yes or N		14. Race - Am	
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ဗ္ဗ	el', o	by	3 X Widowed 4 ☐ Divorced	If Yes, G Year or D	ve Dates:		1 ☐ Yes 2 ☒ No	Specify:			Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or terms 23s or 28s-f show ant, it a Madical Examinar rotat be multified at	Completed	15. Decedent's (Specify only highest g	ducation rade completed	1	16a. Deced	ent's Usual Occupa	ation during most of a	working	16b. Kir	nd of Busines	s/Industry
2	thin 9.	ndu	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use retired	)	· ·			
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Jar	2 sh and Is m	0.9	19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street a					
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0	ges it of h if lite		1 Burial 2 ☐ Cremation 3		State	cemetery, crei	matory or other plac	1				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel; or Items 23a or 28a-f show any injury or other treumatic event, It a Marical Examiner must be notified at once.		'4 □Donation 5 □ Other (Spec		Mo	unt Coi		The second second	16/2007			
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П			shock, or heart failure. List on	y one cause on	each line.	un. Do not sin	ion the mode of dyin	g, 30011 ao 0a10	and or roopmatory	arrost,		Interval Between Onset and Death
	Physician	8 4	Immediate Cause (Final disease or condition resulting in death)	a	Fa	Luve	to H	newe				< Gmonth
r	/Medical Examiner	Due to (or as a consequence of):										<u> </u>
d	nsit	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec		na				-	rigean
N		Examiner	Cause (Disease or injury									Î
m	al-tra	Xa	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):						
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<u>≅</u>	f or Attendated after death	Ě	3 ☐ Suicide 6 ☐ Could not determine	288. Plac	e of Injury - At t ding, etc. (Spec	nome, farm, st <i>ify)</i>	reet, factory, office		28t. Location City or To	(Street an own, State	a Number or i )	Rural Route Number,
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	To the I within 2. To the Complet	Med	29b. Signature and title of certifier	and ma	nner stated.		29c. Licens	e number		29d. Dat	e signed (Mo.	nth. Day, Year)
1	Z × S		REDURAT	MD			Don	61688	,	29d. Date signed (Month. Day, Year)		
	Com		30. Name and address of person wh		is a of death (Ita	m 23a) (Tues		01005			12	I VT
	ES					Di Done	0	wr. 11	retter 1	MO	216	19
	Sta	ite	Runal R. DCS 31. Date filed (App Pan Year) 2		Registrar's Sign	ature	AD L	VU V	-0101			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] ] 1- For Amend PI line a-b, perME, g869, 7/6/07 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** March 2:15 PM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Mary and Medical Center 7 M OV If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Min. 215-77-4421 Nov. 9, 2006 Maryland Director Usual Residence of Decedent nd 2 should be filed within 72 hours after death with the Maryland uith and Mental Hygjene.
27 is marked other than "natural", or items 23a or 28a-f show ritaumatic event, the Medical Examiner must be notified as 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐Yes 2 ☐ No Directo Maryland Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21713 U.S.A. 111 Green Fern Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) N/A College (1-4or 5+) N/A N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evone. Jonathon Hamilton West Jaime Lynn Sweeney P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaime L. Sweeney / Mother 111 Green Fern Circle, Boonsboro, MD 21713 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3/27/07 Blue Ridge Cemetery Thurmont, Maryland 4 Donation 5 Other (Specity) e o Funeral Jervice Licens 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on ach lin. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o shock, or heart failure. Lis-Immediate Cause (Final Metabolic disorder of unknown etiology hysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DIAN Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that in the last of the last Due to (or as a consequence of) CERTIFICATION APPROVED BY MITCHES requires that the death certificate be executed Exam that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No law certificate has 1X Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ို After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Division Year) or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 reenl Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician	
/Medical	
Examiner	

**Funeral** Director

28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County Directo MD. PRINCE GEORGES LANHAM 10e. Street and Number 10f. Zip Code 7122 FORBES BLVD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or ite any injury or other traumatic event, the Medical Examine once. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1942 1 ☐ Yes 2 X No ≥ 3 Widowed 4 Divorced 1964 Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be HARRY R. WOODS 2 19a. Informant's Name/Relationship (Type. Print) MAUREEN H. WOODS/WIFE 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee (Chamlers Immediate Cause (Final **Physician** IMMUNE THROMBOCYTOPENIA diseese or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, nding physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown ned by 2 Completed 25. Was case referred to medical Be Medical Certification: To 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of funeral After Injury 1 Natural 5 Pending ours after death.

neral Director: A
filled in by the fu r death. 2 ☐ Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier and O. Weltz D23743 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 GREENWAY CENTER DR., GREENBELT, MD. 20770 MARTIN WELTZ, M.D. 32. Resistrar's Signature 31. Date filed (Month. Dav. Year)

Day Year Month М EDWIN RENOUF 2007 WOODS MARCH 15, 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death PRINCE GEORGES LAUREL REGIONAL HOSPITAL LAUREL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Months Days Hours 1**∑**M 2□ F 084-18-3769 82 **NEW YORK** APRIL 5, 1924 10d. Inside City Limits 1 ▼Yes 2 No 10g. Citizen of What Country? 20706 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Specify: WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) RET. ARMY MAJOR DEFENSE 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH COBURN WILLETTA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7122 FORBES BLVD., LANHAM, MD. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State CHAMBERS CREMATORY 3-19-2007 RIVERDALE, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

29d. Date signed (Month, Day, Year)

MARCH 16, 2007

				-	artment of Health and	Mental Hygie	ene				
			State Registrar	Cei	rtificate of Death		Reg. No.: () () / () 385				
	nysicia Medic		1. Decedent's Name (First, Middle, Last)  To ha RV 95	II Wei	on ex	2. Date of Death Month	Day Year	3. Time of Death			
<b>)</b> .	kamin		4a. Facility Name (If not institution, give street and	number) DIC	4b. City, Town, or Location of Dea		4c. County of Death				
Form			5. Social Security Number C. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs	8. Date of Birth	Mon 130.				
	neral ector		203-12-5345 15xM 2 F		Months Days Hours Min		(ear) Court 1924 Peni	place (State dr Foreign ptry) nsylvania			
pue		ŀ	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	cation						
Manyl	la pai	5					'	0d. Inside City Limits 1   Yes 2   No			
r 28a-	moth	Director	Maryland   Montgomery  10e. Street and Number	Tal	coma Park	10g	. Citizen of What Coun	ntry?			
death with the Maryland me 23e or 28a-f show	ed la	a D	8213 Sligo Creek Par	kway	20912		USA	,			
er dea	BET	Funeral	Armed	ecedent Ever in U.S. 13. V Forces?	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,				
hours aft	Xecut	by F	If Voc	s 2∏No Give rDates: WWII, Korea	1 ☐ Yes 2 ᡚNo Specify:		Specify:				
Ind XIXID-0030  be filed within 72 hours after tall Hygiene. d other then "naturel", or its	ical E	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupation	. 16	White  b. Kind of Business/Inc	dustry			
dithin 7	- Mari	Completed		e (1-4or 5+)	kind of work done during most of wo DO NOT use retired)	nking					
e filed w	ar.		17. Father's Name (First, Middle, Last)	+ Opthal	Lmologist	me (First, Middle, Ma	Medica:	1			
id be sed o	IC eV	To Be	Russell M. Weimer		Edith Ro		den Surrame)				
Taryla 2 should and Men 1s marke	numa		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or R						
and and the sith of 27	her tr		Ann E. Weimer/ Wife		Sligo Creek Park						
Dattilitore, Intervient ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23e or 28e-1 show	ury or of		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	om State 20b. Place of Disposementary, crem Arlington	natory or other place) Nat'l Cemetery	April 16	c. Location - City or To				
Dall permit. Departr Importu	eny Inj		21. Signature of Funeral Service Licensee	192	Hane ing Address of Essiviir			riginia			
405	<b>●</b> α		230 Parts Established as a sample of the state of the		University BIV						
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of mmediate Cause (Final	n each line.	er the mode of dying, such as cardia	c or respiratory arrest	6011	Approximate Interval Between Onset and Death			
Physic /Med			disease or condition resulting in death)	to (or as a consequence of):	ound hen	d (self in	nylicited)	DME			
Exami			Sequentially list conditions b								
Per	lisit .	Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):							
icate be executed physicien and	ial-tra	Exar	that initiated events	to (or as a consequence of):							
ate be	he bur	dical									
entifica ding pl	98 98		IF FEMALE:								
leath certific	for us	ician/me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year			
thet the de	ache	Phys	1 Yes 2 No 9 Unknown 9 Un		Cition (specify)	1027					
res the	8 .	S P	Part II. Other significant conditions contributing to	6		23e. Did tobac	co use contribute to th	e cause of death?			
v requir	pinous	ered	motaghane c	arcinoma		1 🗆 Yes	2 No 3 □ Proba	ably 4 □Unknown			
D a se	N	ompleted				24a. Was an autopsy performed	prior to con death?	osy findings available inpletion of cause of			
iclan: The	Ö	- C	25. Was case referred to medical examiner?		26. Place of De	1 ☐ Yes 2 ☐ ath (Check only one)	No 1 ☐ Yes	2 No			
Physi this c	( ) ( )	0	1 Yes 2 No Hospitaf: 1 [	Inpatient 2 ER/Outpatient			e 6 Other (Specify	)			
ding Ph.	ē !			te of Injury 28b. Time of Injury 5 2007 An	28c. Injury at Work? ↑ M 1 ☐ Yes 2.25 No	28d. Describe how	injury occurred G	SW			
Attendi	by the	Certification	3 Suicide 6 Could not be determined 28e. Pla	ce of fnjury - At home, farm, stre		28f. Location (Stree	at and Number or Rural	Noute Number,			
itel or rs afte	i be	9	4 I Homicide But	fding, etc. (Specify)		PK Ta	Koma Poll	MO			
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A	etely fil	edical	(Check only 2 Medical Examiner: On the	he best of my knowledge, death basis of examination and/or invi- agner stated.	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the date	a(s) and manner as sit and place, and due to	the cause(s)			
To the within	comp		29b. Sanature and title of certifier		29c. License number	29d.	Date signed (Month, L	Day, Year)			
- 1			30. Name and address of person who completed ca	~ my D mt	D00428	m.	195 15	2007			
1+1			30. Name and address of person who completed ca	use of death (Item 23a) (Type, F	Silver Syri	4 Col P	ark Dr				
	State	9	31. Date filed (Month, Day, Year) 32.	egistrar's Signature	Silver 7/11	no mo	2090	2			
Re	gistra		MAK 1 9 2007	Holes It for	and a						

		Registrar  1. Decedent's Name (First, Middle, La	State of Maryla 9b Per FH G86		uncai	e or L	,caiii	2. Date of		0	3. Time of De
Physici			) A(L					Month	Da	y Year 200	1 47
/Medio		4a. Facility Name (If not institution, giv			4b. City,	Town, or	Location of			c. County of Dea	
Examili	iei	1.		SPITAL	C	Dur	NSIA			HOMA	20
uneral		5. Social Security Number 6. S		. last birthday)	If Under	r 1 Year Days	If Under 24 Hours		Dav. Year	)   0	rthplace (State or Fo
irector		144-42-7913 Usual Residence of Decedent	<sup>(XM 2□F</sup> 69	Yrs.	Mentilo	L			01 .		Turkey
×		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loc	cation						10d. Inside City L
f sho ied al	ō		imore	Dib	cesv:	:11^					1 □ Yes 2
r 28a- notif	Director	MD Balt  10e. Street and Number	Imore	PIN	10f. Zip				10g. C	itizen of What C	ountry?
st be	a D	31 Woodholme A	Ave			21	208			U.S.A	•
"natural", or items 23a or 28a-f show idical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in 1 Armed Forces?	J.S. 13. V	Vas Dece	dent of His	spanic Origi	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Wh	
or its		1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 ☐ No If Yes, Give		I ☐ Yes		Specify:	,			Caucasia
l Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	40- Breed	la atta 1 la	-1 0	Al		105	Kind of Business	
"nar edica	Completed	15. Decedent's E (Specify only highest gra	ade completed)	16a. Deced	kind of wo	al Occupa ork done d ise retired	uring most	of working	100.1	Nina of business	s/industry
than he M	티	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+)  2yrs		stau				В	usines	s Owner
d other than "natu event, the Medical	ပို	17. Father's Name (First, Middle, Last		, ite	Jeau.	<u> </u>		's Name <i>(First, Mid</i>			
	To Be	Ziya Adar					Fatm	a Jale 1	Nurt	opu	
7 Is marked o traumatic eve	-	19a. Informant's Name/Relationship	Type. Print)	19b. Mailin	g Address	s (Street a	nd Number	or Rural Route Nu	mben Gity	or Town, State,	Zip Code)
Cl =		Dolores King-W	Nife					e, <del>Piek</del>			
= =		20a. Method of Disposition  X☐ Burial 2 ☐ Cremation 3 ☐	i i	Place of Dispos cemetery, cren	sition (Nar	me of other place		Date		ocation - City o	
ant: # ury or		4 □ Donation 5 □ Other (Speci		) Natio	onal	Par	k 4	/2/07	La	urel,	Md
Important; If any injury or once.		2. Signal vie d' Funeral Service Lice	nsee MMA	M2 43	Namear 300 I	<sup>nd</sup> fが判 Waba	wes sh a	t ve, Bal	timo	re, Md	21215
		23a. Part1 Enter the disease, or com shork, or heart failure. List only	oplications that caused the dea	ath. Do not ente	er the mod	de of dying	g, such as c	cardiac or respirator	y arrest,		Approximate Interval Between
sician		Immediate Cause (Final diseas) or condition	ACUTE 1	MYSCAN	201A	7 1	NFA	RCTUM			Onset and Dea
Medical	1	resulting in death)	Due to (or as a conse		5017						
niner		Sequentially list conditions.  b. HYPERKALEMIA									24 H
#	iner	Sequentially list conditions, if any, and is to find the cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conse								3 DA
and trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	ROMAS	- 1-4	7 1-08					7 01
physician and the burial-transit	高 円 円		Due to (or as a conse	quence oi).							
physi the i	dical		<b>d</b>								
lding Ise as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg	nancy						23d. Date of de	elivery
attending p	ciar	in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		]Ectopic p ]Other (s					Month	Day Yea
by the stached	ysi	9 Unknown	9□Unknown								
pe ee	by Pl	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	nderlying o	cause give	n in Part I.	23e. D	id tobacco	use contribute	to the cause of dea
n sign uld be	d b	CONDINARY ART	BRY DISPASE					1	Yes	2  No 3	Probably 4 □Uni
s been 2 should	Completed	DIABETES MET	4705					24a. V	vas an utopsy	24b. Were	autopsy findings ava
page 2	E	ITYPEXCIBLEST	FOR BANG						erformed?	death?	)
certificate rector, pag	0	25. Was case referred to medical examiner?					26. Place	of Death (Check or			
양병	To B	1 Yes 2 No	Hospital: 1 npatient 2	☐ ER/Outpatien	t 3□ D0	OA Othe	er: 4□ Nur	sing Home 5 🗆 F	tesidence	6 □Other (Sp	ecify)
After th funeral		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f :	28c. Injury Work	at ?	28d. Descri	be how inj	ury occurred	
or: A the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	_		М		∕es 2□N				
Director:	ŧ	4 Homicide determined		home, farm, stre cify)	eet, factor	ry, office			n (Street a Town, Sta		Rural Route Numbe
To the Funeral Discompletely filled is		(Check only 2 Medical Exa	hysician: To the best of my ki miner: On the basis of exami								
the I	Medical	one)	and manner stated.		20	c. License	number		20d D	ate signed (Mo	nth Day Voor)
0 0	-	29b. Signature and title of certifier	payon w	D	1			4	)	29   0°	
- 0		_ " . ~ ~ ~ ~ ~	The contract of the contract o	V		1/ /	<i>ا ر د</i>	7	1021	2)10	7
-0	,	30. Name and address of person who	1								MD 210

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Anderson 10:45aM 03 31 2007 Louise Vivian 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2X □ F 39 67 MD 06 16 215-88-0981 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21207 3301 Firelight Lane apt J Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Columbia Academy Teacher 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Watkins John M Cunningham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 1521 Kirkwood Road, Baltimore, Md Douglas Anderson-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XIXBurial 2 □ Cremation 3 □ Removal from State Randallstown, Md Memorial Park 4/7/07 Donation 5 ☐ Other (Specify) Funeral Service Lice 22. Name and Address of Facility March F H West 4300 Wabash Ave, 21. Sign 21215 Baltimore, Md 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death prediate Cause (Final ease or condition sulting in death) Kidney Canco months Due to (or as a onsequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

ms 23a or imust be n

7 is marked other than "natur traumatic event, the Medical

1 and 2 should be fill Health and Mental H tem 27 is marked ott

permit. Pages 1 and Department of Health Important: If item 27 any injury or other traonce. of Health

with the Maryland

0.45 Am

Inderson, Vivian

Baltimore, Maryland 21215-0036

burial-trar physician a attending p for use as ed by the a

Exami Physician/Medical þ Completed Be Certification: To after death

Director:

to the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

		TE Yes 2021NO TE YES 2E NO									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursi	ing Home 5 ☐ Residence 6 Ø Other (Specify) WDSFIQ									
27. Manner of Death  1		28d. Describe how injury occurred									
3 Suicide 6 Could not t 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Continue 1 Continue P	bucinian. To the best of my knowledge, death occurred at the time, date and	place, and due to the cause/s) and manner as stated									

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 0

29c. License number 29d. Date signed (Month, Day, Year) March 31 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

harles St TONSON MO 21204 6701 J. Charles WD

State Registrar 32. egistrar's Signature

within 24 hours after To the Funeral Di completely filled in

			For State Registrar	State of I	Maryland		artment rtificate			and M		giene Reg. No		10388
	Physici /Medio Examin	al	Decedent's Name (First, Middle     Linda Ainola     Facility Name (If not institution,		er)		4b. City,	Town, or	Location o	of Death	2. Date of De Month	Da 28	y Year	6:10 A <sup>M</sup>
	Funeral Director	lei	Genesis Elder 5. Social Security Number 216-26-7147	care	Age (In yrs. last	birthday) Yrs.	_	Zerna 1 Year Days			8. Date of Bir (Month, Da Sept.	th		rundel inhplace (State or Foreign Sountry) Estonia
	he Maryland 28a-f show puffied at	ector	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  MD  Anne Arundel  Severna Park  10e. Street and Number  10f. Zip Code									10a Ci	tizen of What C	10d. Inside City Limits 1 ☐ Yes 2√ No
920	72 hours after death with the Maryland Instural; or Items 23e or 28e-f show Jisal Examinat must be notified at	Completed by Funeral Director	10e. Street and Number  24 Truck Hous  11. Marital Status  1 Never Married 2 Marrie  3 \( \text{Widowed} \) 4 \( \text{Divorced} \)	12. Was Decede Armed Force	s Decedent Ever in U.S. ned Forces? If Yes 217 No es, Give 1			21146  Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No Specify:					nited S 14. Race - An Black, Wh	States nencan Indian,
d 21215-0036	filed within Hygiene. sther than "		15. Decedent (Specify only highes Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L	college (1-4		(Give life.	dent's Usua kind of wor DO NDT us inder	k doné d e retired)	uring most		ng (First, Middle	L	ind of Busines Library  Sumame)	s/industry
Maryland	id 2 should th and Men 27 is marke traumatic	To Be	UNKNOWN  19a. Informant's Name/Relationsh				-		nd Numbe	r or Rura		er, City	or Town, State, MD 212	
σĵ	permit. Pages 1 an Department of Heal Inc. 1 if item 2 In injury or other pnce.	C	2 a. Method of Disposition  1 St Burial  2 Cremation  14 Construct 5 Other (Sp  21. Fig. sture of Funery Service)	3 □Removal from State	20b. Plac	e of Dispo etery, crea akevi	esition (Name matory or of ew. Mei ark 2. Name and	ne of ther place MOTI d Address	al 3	3/30/ Mark	'2007 Prose F	20c. L S uner	ocation - City o ykesvi al Home	n Town, State 11e, Mb e of Lansdown
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or	sed the death. In line.	al ace of):	,		1		dise			Approximate Interval Between Onset and Death
8760, تر	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequen									
P.O. Box 6	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		2 ☐ Fetal de t at time of deatl	ath 3	⊒Ectopic pre ☐ Other (spe						23d. Date of d Month	elivery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant condition	ns contributing to deat	h but not resultir	ng in the u	nderlying ca	ause give	n in Part I.		10	Yes 2	□No 3□I	to the cause of death?  Probably 4 Donknown
Vital Records,		Be Completed	25. Was case referred to medical examiner?							of Death	24a. Was auto perfo	psy ormed? 21140	prior to death?	
o o	ding Phys h. After this funeral di	Certification; To	1 Yes 20 No 27. Mann of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could n	ation of be		Outpatier b. Time o Injury	f 28	8c. Injury Work 1 🔲 Y	4 V IVU	No	28d. Describe	how inju		ecify) Rural Route Number,
οį	Hospital or 4 hours afte Funerel Dir tely filled in t		(Check only 2 Medical E	physician: To the be examiner: On the basis	etc. (Specify) est of my knowle s of examination	dge, deat	h occurred a	at the time	e, date and	d place, a	City or To	cause(s	and manner	as stated. ue to the cause(s)
	To the within 2 To the complet	Medical	29b. Signature and title of ceptifier	and manner	stated.	MI	290	License	number 070	15		29d. Da	te signed (Moi	nth, Day, Year)
	Sta Registr	_	30. Name and address of person of the person	100	of death (Item 23	Ve	Print)		Hw	4/	N. U	erci	ille,	- 2007 MD 21/08

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Ma	ryland	•	artment of F			_	, m, m, em	10000		
			Registrar  1. Decedent's Name (First, Middle, La.	st)		06	itilicate of	Death	2. Date of De	Reg. No	2011	3. Time of Death		
	Physicia		Melvin L.						April	1. <sup>Da</sup>	2007 Year	10:02PM <sup>M</sup>		
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Deat		_	c. County of Death	10.02111		
1	Lxamin	Ç!	6413 Kipling Pk				Distri	ct Height	S	P	Prince Ge	orge's		
ī	Funeral		5. Social Security Number 6. S		(In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th av. Year	9. Birth	place (State or Foreign		
	Director		230-34-1591	Dxm 2□ F   81		Yrs.	World bays	Tiours Iviin.	July	22,1	925 Vir	ginia		
ī	p ,		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	ocation					10d. Inside City Limits		
	laryla shov sd at	'n			100. Oity			1				1 ☐ Yes 2X☐ No		
	the N 28a-f potifie	Director	Maryland Prince G	eorge's		Dis	trict Hei	gnts		10a Ci	itizen of What Cou	ntry?		
	with la or t be r	ă	6413 Kipling Pa	rkwav			20747	7		,-				
	leath	Funeral	11. Marital Status	12 Was Decedent F	ver in U.S	S. 13.	Was Decedent of H		Specify Yes or No	o-	U.S.A.	can Indian,		
	r iter	Fur	1 ☐ Never Married 2 X Married	Armed Forces? 1/2 AYes 2 ☐ No	。194	+4-			to Rićan, etc.)		Black, White,			
Ś	al", o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	194	46	1 □ Yes 2√0XNo	Specify:			Specify: Whi	Le		
	72 ho natur lical	Completed	15. Decedent's Ed (Specify only highest gra	Jucation ade completed)			dent's Usual Occup		rkina	16b. k	Kind of Business/In	dustry		
1	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+	+)		e kind of work done DO NOT use retire	d)	9					
1	led w lygier her th	S	8th			Weld	er	10. Matharia No.	ma /First Afiddle		Iron Ind	ustry		
	be fi	Be	17. Father's Name ( <i>First, Middle, Last,</i> William All						ulina E		Maiden Surname)			
,	hould d Me mark matic	٦	19a, Informant's Name/Relationship (			mber, City or Town, State, Zip Code)								
3	id 2 s Ith an 17 is trau			Wife)		1	-			-	t Heights, MD 20747			
5	Heal Heal		20a. Method of Disposition		20b. Pl	lace of Disno	osition (Name of	i A			ocation - City or To			
2	ages ent of nt: If i		1 ⚠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				matory or other pla Veterans	/ - ! -	007	Che	ltenham.	Maryland		
To a. State   10b. County   10c. City, Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Location   10c. City Town or Lo														
ĭ	any any one		MADELLA	120015	3							n, MD 20735		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death	. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory a	arrest,	0	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Caron		Oba	Tructur	a Phil	MARKEN	$\mathcal{L}$	132202)	Onset and Death		
6	/Medical		resulting in death)	Due to (or as a	consequ	uence of):		1	)					
	Examiner	_	Sequentially list conditions.	b										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	ı consequ	ience of):								
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	consequ	uence of);								
	be e sician buria	lical E				,								
	ficate physics the l	edic		-d										
<	leath certifica attending ph I for use as th	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p							23d. Date of deliv	rery		
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at t			□Ectopic pregпanc □ Other <i>(sp</i> ec <i>ify)</i> _	у			Month	Day Year		
	ires that the de signed by the a be detached i	Physician/Med	9 ☐ Unknown	9□Unknown										
, )	as the gned se de	by P	Part II. Other significant conditions	ontributing to death bu	t not resu	ılting in the u	ınderlying cause giv	en in Part I.				the cause of death?		
5	w requir been si should I		Mergheril a	merial	Juse	ase			10	Yes 2	2 No 3 Pro	bably 4 🕅 Unknown		
	has be	ple	Hyper chole	Steroleme	-				24a. Was		prior to co	opsy findings available ompletion of cause of		
	The ate h	Completed	00						perfo	ormed? 2 X	death?	2 □ No		
3	clan: ertific	Be (	25. Was case referred to medical examiner?				l au		ath (Check only	one)				
5	Physician: The la	7	1 Yes 2 No	Hospital: 1 Inpatier				ner: 4 Nursing H			6 □Other (Speci	fy)		
	ding F h. After funera	ion	27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	Wor	ryat rk?  Yes 2∐No	28d. Describe	now inju	ury occurred			
2	death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not b	e 29a Place of injur	rv - At ho	me. farm. st	reet, factory, office	7103 2 110	28f. Location	(Street a	and Number or Rur	al Route Number		
2	after Direction by	Certification:	4 ☐ Homicide determined	building, etc.			, ,		City or To			ar riodio ridingo,		
	spita nours neral y filler			nysician: To the best o										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner stat		tion and/or ii	nvestigation, in my	opinion, death occ	urred at the time	, date ar	nd place, and due	to the cause(s)		
	To the complete compl	Ž	29b. Signature and title of certifier	1			29c. Licens			29d. D	ate signed (Month,	Day, Year)		
)			Thurand				V43	274		Apri	1 2, 20	0-1		
	1011		30. Name and address of person who				, Print)	#106 II-	M 1	hor	MD 207	70		

Imelda Miranda, M.D.
31. Date filed (Month, Day, Year)
APR 0 3 2007

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Patricia Lee Adriani March 29. 2007 10:29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Director 577 38 7890 76 Jan 3, 1931 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show at 1 □Yes 2□No notified Director Maryland Prince George Camp Springs 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in 4910 Braddock Road United States
14. Race - American Indian, 2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "natural", or items 23s Funeral 20748 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Francis Jennings <u>Virginia Irene Ellis</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau Dominick Adriani (Husband) 4910 Braddock Road, Camp Springs, Md 20748 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory April 2, 2007 Clinton, MD 22. Name and Address of Facility Lee Funeral Home., Inc. 6633 Old 21. Signature of Funeral School Licer Alexandria Ferry Road, Clinton, MD 20735 MO0257 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Intraceretoral Acrite disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Iding physician and Ise as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 🗹 No o 9 ☐ Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Severe Coagnopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen (a) Pailyon Seresz Thornbocytopenia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 3 Acute Renal Failux certificate 2**X**Xlo 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes XX No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Funeral Director; After completely filled in by the funera or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifier

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-1)

(Shavin

31. Date filed (Month, Day, Year)

D0064801

3/29/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 25, 2007 4c. County of Death 3:54 PM March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Memoria **Funeral** Days Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County Od. Inside City Limits show r 28a-f sh notified MD 1 es 2 No Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code ns 23a or must be r Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. d other than "natural", or iten event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 o þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, # 17. Father's Name (First, Middle, Last) (First, Middle, Maiden Surname) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Baltimore, ethod of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signatur of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a consequence of): Drs /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 21 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3X DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 🗌 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D61580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASARO E. Univeril Enegenen 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#26, perVIRB. G866, 4/3/07, WS State of Maryland bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Physician Clifton 3: 32PM Brown MARCH 2007 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9000 SAMIARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) 2 24 19. Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 215-30-3763 73 Yrs Director Usual Residence of Decedent death with the Manyland 10d. Inside City Limits 10a State 10h County 10c, City, Town or Location or 28a-f show other treumatic event, the Madical Examiner must be notified at 1X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4806 Lorelly Avenue 21206 items 23a U S Α Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry NA NA (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be tiled within 72 h and Mental Hygiene. 7 is marked other than "ne College (1-4or 5+) Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last) NA Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) ROEN Pages 1 and 2 should be Samuel Brown Ruth Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tree soce. Emily Brown-Wife 4806 Lorelly Avenue Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Greenmount Cem 4-2-2007 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) March F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gla 1101 E. North Avenue Balto, MD 21215 dig Warre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HOURS PNEUMONIA MULTILOBAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (di as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit attending physicien and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown LIVER DISEASE ALCOHOLIC Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? HEPATITIS autopsy performed certificate 2□ No 1 Yes 2 No 1 Yes o the Hospital or Attending Physicien: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Natural 5 Pendina death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
APR 0 3

ROSHAN

MD 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

DHAWALE

2007

DHMH 17 Rev 1/2001

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Gosali.

5601

32. Registrar's Signature

29c. License number

RES DOG

RAUEN

29d. Date signed (Month, Day, Year)

MARCH 30 2007

BALTIMORE dia 30

			1 - For State Registrar	State of Mary		artment of I <i>rtificate of</i>			giene Reg. No. 2007	7 10393	
	Physici		1. Decedent's Name (First, Middle, Last,	vassa				2. Date of Dea Month	Day Year	11 1 1 1 1	
	/Medio Examir		4a. Facility Name (If not institution, give Genesis Long Green	street and number)		4b. City, Town, o Baltimor		ath	4c. County of Dea		
	Funeral Director		5. Social Security Number 6. Se. 002-20-8952	7. Age (II M 2□F 75	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours M		r <sup>y</sup> 30, 1931	rthplace (State or Foreign country) New Hampshire	
	he Maryland 8a-f ehow ctiffed at	ector	10a. State 10b. County  Maryland N/A	10	oc. City, Town or Lo Baltimor	e				10d. Inside City Limits 1 □ Yes 2 □ No	
	23a or 2	Funeral Director	10e. Street and Number 124 West Franklin Stre	et #1207		10f. Zip Code 21201			10g. Citizen of What C USA	Country?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *natural'; or items 23s or 28s-f show any highry or other traumatic event, the Medical Examinar must be notified at ance.	þ	11. Marital Status  1 M Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates:	1961	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛱 No	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.	
21215-0036	d within 72 h giene. or then "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary(Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Relations	oation during most of v d)	vorking	16b. Kind of Business  Catholic Re		
Maryland	ould be file Mental Hygarked otheratic event,	To Be C	17. Father's Name (First, Middle, Last) Aimee Bourassa				Delvina	lame (First, Middle, Beaulieu			
	and 2 shi salth and 127 le m er traum		19a. Informant's Name/Relationship (Ty Cynthia Piper/Niece	pe, Print)		ng Address (Street x 1016 Asl		Rural Route Numbe V Hampshire	r, City or Town, State, 03217	Zip Code)	
altimore,	Pages 1: ment of He ant: If Iten lury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, crea Hilltop Se	natory or other pla		Date /3/07 T	20c. Location - City o Towson Maryla		
Balt	Depart Depart Import any inj		21. Signature of Funeral Service License	Helton	5	eonard J. 305 Harford	d Road Ba	itimore Mar	yland 21214		
Air	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	death. Do not ent	٨	ng, such as card	ac or respiratory ari	rest,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)  Sequentially list conditions,	Due to (or as a co	2 hyper	Hension	$\cap$			un Known Un Known Un Known	
	xecuted and al-transit	Examiner	d								
68760,	ificate be executed physicien and as the burial-transit	dlcal									
P.O. Box	The law requires that the death certificate be executed ite has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	olivery Day Year	
rds, P	w requires that been signed b should be deta		Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute tes 2 No 3 P	to the cause of death?	
Division of Vital Records,		Completed	Chama ET	Su abuse	1			24a. Was a autope perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of s 2 No	
f Vita	Physician: The Ithis certificete ha	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	2 ER/Outpatier	it 3□ DOA Oth	or /	eath (Check only or Home 5 Resid	ne) ence 6 □Other (Spe	ecify)	
o uo	Attending Physician: r death. ector: Alter this certific by the funeral director.	atlon;	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	Wor	yat rk? Yes 2∐No	28d. Describe h	ow injury occurred		
Divis	afte Dir	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number or Fi π, State)	lural Route Number,	
	To the Hospitel or within 24 hours after to the Funeral Dir. completely filled in I	Medical	29a. Certifier (Check only one)  1 Certifying Physical Cartifying	sician: To the best of more: On the basis of exa and manner stated.	y knowledge, death mination and/or in	n occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the c curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)	
A.	withir To th	M	29b. Signature and title of certifier	MD		29c. Licens	177900	88	29d. Date signed (Mon	th, Day, Year)	
1	X		30. Name and address of person who co	1 /		Print) D'TAL AU	E RAI	TIMORE	21217		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Referar's		0-0-					

DHMH 17 Rev 1/2001

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			1 - For Stete Registrer		aryland / D		nt of H	lealth and M	ental Hyg	iene	7 10394	
	Physici		1. Decedent's Name (First, Middle, Last, Helena	М.		В	uncl	h	2. Date of Death	Day Ye		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	11			r Location of Death	Q. 1.	4c. County of D	7 170	
	Funeral Director		5. Social Security Number  215-74-4506  Usual Residence of Decedent		e (In yrs. last birth	nday) If Under Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day 10 07	Year) 9.	Birthplace (State or Foreign Country) MD	
-:-	aryland show	_	10a, State 10b. County		10c. City, Town			.,			10d. Inside City Limits	
releng	r 28a-f ehow	recto	MD NA  10e. Street and Number		Bait	imore	p Code		10	g. Citizen of Whal	1 Yes 2 No	
0	ath with	rai Di	6501 Fairmount				2	1215		U.S	•	
	within 72 hours after death with the Maryland see. I show then "natural", or items 23e or 28e-f show then "natural" and the natified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		lispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		merican Indian, /hite, etc. Black	
20Ch ,	within 72 hours ine. Then "natural", Medical Ex	Be Completed	15. Decedent's Edu (Specify only highest grad	e completed) College (1-4or 5	life. DO NOT use retired)			during most of working i)	g	6b. Kind of Busine U.S. Fe	deral	
Baltimore Maryland 21215-0036	s 1 and 2 should be filed v I Health and Mental Hygie Item 27 is marked other t other traumatic event, III	To Be Co	12th Grade  17. Father's Name (First, Middle, Last)  Joseph Neale Sr	na •		superv	150	18. Mother's Name	(First, Middle, M	Reserve faiden Sumame)	Bank	
2	12 shouh and N	1	19a. Informant's Name/Relationship (Ty	rpe, Print)				and Number or Rural				
910	permit. Peges 1 and Depertment of Health importent: if item 27 eny injury or other tr		Christopher Bun  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State	20b. Place of I cemetery	Disposition (Na crematory or in Memori	me of other plac	Ave, Hal	ate 2	0c. Location - City		
<u>.</u>	permit. F Depertm importer eny injur		21. Signature of Funeral Service Licens			22. Name a March	nd Addres					
C	Physician /Medical Examiner		23a. Part1. Enfer the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Acu	the death. Do note.	10(00	de of dyin	g, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death	
Zeo Zeo	P C B	icai Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):									
P.O. Box 687	sath certifica attending ph for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death		23d. Date of Month	delivery Day Year				
	w requires that the de been signed by the should be detached	2	Part II. Other significant conditions cor	ntributing to death bu	23e. Did tob	10	e to the cause of death?  Probably 4 □Unknown					
Division of Vital Becords	> 0 0	e Completed	25 Was and the state of the stat							prior death	autopsy findings available to completion of cause of ?? es 2 \( \sum \text{No} \)	
, , ,	hysicia his certi i directo	To Be	25. Was case referred to medical examiner? 1	lospital:	nt 2 12 VOutp	patient 3 D	Othe Othe	26. Place of Death er: 4 \(\sum \) Nursing Hom		nce 6 Other (S	pecify)	
00	Attending P r death.	ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	y 28b. Tir Year) Inj	me of ury M	28c. Injury Work	/ at 26 (? Yes 2 ☐ No	Bd. Describe how	v injury occurred		
Divis	To the Hospitel or Attending Physicien: The law within 24 hours eller death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm . (Specify)	n, street, factor	y, office	2.	Bf. Location (Str. City or Town,		Rural Route Number,	
	Hospi 24 hou Funer etely fill	Medicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sicien: To the best oner: On the basis of and manner state	examination and/	death occurred or investigation	at the tim	ne, date and place, as pinion, death occurre	nd due to the car d at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifier	MM	)	29	c. License	063991	29	d. Date signed (Mo	onth, Day, Year)	
	20		30. Name and ddress of person to co	impleted cause of de	eath (Item 23a) (T	ype, Print)	. \	Mospita	1	R. 1+	inoxo	
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	boortes	1.	11-11-10	1 0		1. 01	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician BROWN 00 PM STELLA MARCH 28 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAYVIEW MEDICAL BALTIMORE JOHNS HOPKINS 8. Date of Birth (Month, Day, 12 01 Year) 23 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 83 NC **Director** 220-22-4001 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Director MD NA 1 □XYes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ns 23a must b 21218 1230 Bonapart Ave U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status "natural", or item edical Examiner Black, White, etc. 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Black Specify: à 3 Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th grade na Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Percy Nicholson Estell Edmonds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathaniel Brown-Son 1230 Bonapart Ave, Baltimore, 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donalipn 5 ☐ Other (Specify) Memorial Park 4/3/07 Randallstown, 21. Signature of Funeral Service Licersee 22. Name and Address of Facility

March F/H West Home\_ hompeon 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 4 DAYS /Medical Due to (or as a consequence of): Examiner NULTILOBULAR 14 DAYS Sequentially list conditions, if any, localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for ws a consequence of: Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe MYELODYSPLASTIC 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an FAILURE page 2 s autopsy HEART FAI 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral ( 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

completely

within 2 To the

Medical

State

29a. Certifier

(Check only

29b. Signature and litle of er

31. Date filed (Month, Day,

BRIAN

Year)

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

4940

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

EASTERN AVENUE BALTIMORE, MD 21224

and manner stated.

SILVERMAN

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

07-02325 Noah Barnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle Last) Physician/ 2 Date of Death 3. Time of Death March 27, 2007 **Medical Examiner** 0627 hrs David Barnes Noah 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Director 25 Months 03 1X M 2 F 12 02 06 Country) MD 215-77-7984 Yrs Usual Residence of Decedent any 10a State 10b County 10c. City. Town or Location 10d Inside City Limits s 23a or 28a-f show 1 Xes 2 No 28a-f show Baltimore MD NΑ with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21229 U.S.A. ā 402 South Wickham Road Apt C Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married 2 X No Yes 0 Black 3 Widowed If Yes, Give Year 1 Yes 2 XNo specify: Divorced Pages I and 2 should be flied within 72 hours after tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examing. Specify 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Baltimore, MD 21215-0036 N/A N/A 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Braggil Barnes Be Corey Livingston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6619 English Oak Road Apt J. Parkville 19a. Informant's Name/Relationship (Type, Print) Md Corey Livingston-Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4/2/07 Arbutus Memorial arbutus, Md Donation 5 Other Specify 21. Signature of Funeral Service Licensee March F/H West al n Tar 4300 Wabash Ave, Baltimore, 21215 Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Retween Onset and /Medi al Death Complications of upper respiratory infection Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Litter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED 27, perME. attending physician or use as the burial g868. 6/21/07 TI Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ⋧ σ. 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24b Were autopsy findings available 24a Was an autopsy prior to completion of cause of aw I this certificate has performed? death? The 1 ✓ Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Hospital 1 / Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes After t 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director; the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifig 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. March 28, 2007 askel 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signalire State

Registrar

2007

**Physician** /Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

**Funeral** 

Director

Physician /Medical

For State Registrar			partment of Health and Nertificate of Death	Reg. N		1000			
Decedent's Name (First, Middle, I	Last)			2. Date of Death	2001	3. Time of Beath			
Margar	et M. Burke			March 22,	ay Year	10:30 P M			
a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
Bradford Oak	s Nursing Hom	ne	Clinton		Prince George's				
5. Social Security Number 6 229 01 3126	. Sex 7. Age (/	n yrs. last birthdaj Yrs.	// If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea		hplace (State or Foreign			
Jsual Residence of Decedent	W-W 03	115.		Dec 8, 19	17   Vir	ginia			
0a. State 10b. County	10	oc. City, Town or I	ocation			10d. Inside City Limits			
Maryland Prince	George's	Clinton				1 □ Yes 2 🛣 No			
0e. Street and Number		1010	10f. Zip Code	10g. C	itizen of What Co	untry?			
8600 Mike Shap	iro Drive Apt	: 1013	20735		United S	States			
1. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, White				
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 ☐ Yo Specify:	, ,		nite			
15. Decedent's (Specify only highest)	Education grade completed)	16a. Dec	edent's Usual Occupation re kind of work done during most of wori DO NOT use retired)	ting 16b.	Kind of Business/	Industry			
Elementary/Secondary (0-12)	College (1-4or 5+)		ired/ Home Owner	I	usewife				
1 Z 7. Father's Name ( <i>First, Middle, La</i>	est)	Wer		e (First, Middle, Maide					
Edward G.				n Duggon					
9a. Informant's Name/Relationship	(Type. Print)	19b. Mai	ling Address (Street and Number or Ru	ral Route Number, City	or Town, State, 2	Zip Code)			
Pat Raicich (Da	ughter)	920	O6 Midland Turn, U	pper Marlbo	ro, MD	20772			
0a. Method of Disposition		20b. Place of Dist		- T	ocation - City or	Town, State			
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			ction Cemetery Mar	ch 26,2007	Clintor	n, MD			
1. Signature of Funeral Service Lic	91	_	22. Name and Address of Facility L Alexandria Ferry R	ee Funeral		6633 01d 20735			
23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the		nter the mode of dying, such es cardiac			Approximate Interval Between			
mmediate Cause (Final disease or condition	ATHERD	8 levolic	and Diby Asah	a ChIET	٤	Onset and Death			
esulting in death)	Due to (or as a c	onsequence of):	- 1 - 0/0/////			yuna			
Sequentially list conditions.	b								
Sequentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury	Due to (or as a c	onsequence of):							
hat initiated events esulting in death) Lest	c Due to (or as a c	openguance of):							
	Due to (or as a c	brisequerice oi).							
	d								
IF FEMALE:	23c. If yes, outcome pf	oregnancy			23d. Date of del	iven			
23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year			
1 ∐ Yes 2 <b>∑ N</b> o 9 □ Unknown	9□Unknown								
art II. Other significant conditions	s contributing to death but n	ot resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?			
				1 ☐ Yes	2 <b>∏</b> No 3□ Pr	obably 4 □Unknown			
				24a. Was an	24b. Were au	utopsy findings available completion of cause of			
				autopsy performed? 1 Yes 2 X	prior to death?				
5. Was case referred to medical			26. Place of Dea	1 Yes 2 N th (Check only one)	I ∐ Yes	2 □ No			
examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient	2 ER/Outpatio	Other:	ome 5 Residence	6 ☐Other (Spec	cify)			
7. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time Injury	of 28c. Injury at	28d. Describe how inj					
2 ☐ Accident investigat	ion	,3.,	M 1 ☐ Yes 2 ☐ No						
3 ☐ Suicide 6 ☐ Could not	be on Di	At hama farm a	treet, factory, office	28f. Location (Street a	141				

The law requires that the death certificate be executed attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for After this certificate To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

Physician/Medical IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 💢 9 Unknown Part II. Other signific δ Completed 25. Was case referre examiner? Be 1 Yes 2X N Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide City or Town, State) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated. 29a. Certifier Medical (Check only one)

29c. License number

D19431

29d. Date signed (Month, Day, Year)

State Registrar

Livingston Road # 103, Fort Washington, MD 11701 Frank Ryan, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

29b. Signature and title of certifier

APR 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 0 2 2007

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - Stata		State of	of Mary	/land / I		irtment of tificate of	Health and	Mental H		4001		1399
1			Registrar  1. Decedent's Nam	e (First, Middle,	Last)			061	inicate of	Dealii	2. Date of I				ne of Death
	Physici /Medi		Adalbert	Beli							March	31,	<sup>2</sup> 2007	8:	55 A M
	Examir	ner	4a. Facility Name (			mber)		:	4b. City, Town, Parkvil	or Location of Dea	ath		sc. County of De Baltimor		
	Funeral	-	5. Social Security N	lumber 6	. Sex		yrs. last bi		If Under 1 Year Months Days	r If Under 24 Hr	S. 8. Date of E	lieth	0.5	Sirthplace (Si	ate or Foreign
	Director		215-03-7 Usual Residence o		1 M 2 □ F	93		Yrs.	months bays	710010	Mar.	31,	1914	Mary 1	and
	ryland how		10a. State	10b. County		10	c. City, Tow	m or Lo	cation						de City Limits
	8a-1	ector	MD	Baltimo	re		Parkvi	11e							Yes 2 No
	th with the 23a or 2	al Dire	10e. Street and Nu 8832 Wal		d.				10f. Zip Code 21234			USA	Citizen of What	Country?	
96	If Z 1Z 15-0050 filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or Iteme 23a or 28s-1 ehow ont, the Medical Exament must be instilled at	Completed by Funeral Director	11. Marital Status 1 Never Marr 3 Widowed	ied 2□ Married	12. Was Dec Armed Fo 1 1 Yes If Yes, Gi Year or D	2 □ No ve	r in U.S.		Vas Decedent of Yes, specify Cul	Hispanic Origin? (ban, Mexican, Pue	(Specify Yes or to into Rican, etc.)	No-	14. Race - Ar Black, Wi Specify:		
2	72 hou natura	ted		15. Decedent's			16a	Deced	ent's Usual Occu	pation	orkina	16b.	Kind of Busines		-
101	within and the within	mple	Elementary/Seco		College (	1-4or 5+)	Who		aler	during most of weed)	orking	FI	orist		
Ţ	e filed vall Hygie other I	Be Co	17. Father's Name	(First, Middle, La	st)		MIIC	7163	alei	18. Mother's N	ame (First, Midd				
2	should be nd Mental markad c	To B		Unknown						Unkr	าอพท				
Politimoro Mondond 2424E 0006	ges 1 and 2 should be filed to Health and Mental Hygis I if item 27 is marked other or other traumatic event.		19a. Informant's N			nal Re				tand Number or F / <b>lvania</b> /		. ,		. , ,	
9	es 1 and 2 of Health of litem 27 l		20a. Method of Dis	position		2	Ob. Place o	f Dispos	sition (Name of patory or other pla	1	Date		Location - City		le
į	Pages ment of I		1 Burial 2 4 Donation	Cremation 3 5 Details (Spe	☐Removal from cify)	State		-		orp. 4/2	/07	To	wson, M	D	
- C	permit. Page Department of Important: if any injury or once.		21. Signature of Fu	in ra/Service U	ente				Name and Addr	ess of Facility on Funera	1 Home		.050 Yor owson,		
			23a. Part1. Enter t shock, or hea		mplication hat d ly one car le on e	aused the ach line.	death. Do	not ente	r the mode of dy	ing, such as cardi	ac or respiratory	arrest,		Approx Interva Onset	imate I Between and Death
	Priysician /Medical		Immediate Cause disease or condition resulting in death)	(Final in	a	wm	msequence	of): I	Sactor	m 1				1 de	
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Ma.	w requires that the death certifue on the standard of the attending should be detached for use as	Physician/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?		oirth 2 🗌 nant at time	Fetal death		Ectopic pregnand Other (specify) _	ey			23d. Date of d Month	elivery Day	Year
P	v requires that	þ	Part II. Other signif	icant conditions	contributing to d	eath but no	et resulting in	the un	derlying cause gi	ven in Part I.		tobacco	use contribute		of death?
Second Property	law 2 sb	Completed									24a. Wa aut per 1 🗆 Yes	opsy formed?	death?	autopsy findi completion	ngs available of cause of
	ician: certific ector,	Be	25. Was case refer examiner?		Hospital:						eath (Check only				
	Phys arthis aral dir	To	1 Yes 2		28a Date	of Injury	2 ER/Ou	tpatient lime of	3 DOA 28c. Inju		Home 5 Res			ecify)	
	Attending Physician: r death. sctor: After this certific. by the funeral director.	atlor	1 ☑ Natural 2 ☐ Accident	5 Pending investigat	on	th, Day Yea	ar) l	njury		irk? ]Yes 2 □No		,	-,		
	or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286 Place	of Injury - ng, etc. (S	At home, fa pecify)	rm, stre	et, factory, office		28f. Location City or To	(Street a	and Number or I te)	Rural Route	√umber,
_	Hospital or 24 hours afte Funeral Dir tely filled in	al Ce	29a. Certifier	1 Certifying I	Physicien: To the	best of my	y knowledge	, death	occurred at the ti	me, date and place	e, and due to the	e cause(	s) and manner	as stated	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical	(Check only one)	2 Medicel Ex	eminer: On the b	asis of exa	mination an	d/or inv	estigation, in my	opinion, death occ	urred at the time	, date a	nd place, and di	e to the cau	3 <b>e</b> (s)
	To To To E	Σ	29b. Signature and	title of certifier	1 m				29c. Licen	se number	-	29d. D	ate signed (Mo	nth, Day, Yea	r) 1
	no		30. Name and addr	ess of person wh			(Item 23a)	Type F	Print)	2 21/1		170	1 10.	200	<i>J</i>
	7		745.	600g	non	STO	> (	ا بن ند	itiv B	10 10	uku (la	N	0 213	237	
	Sta Registr		31. Date filed (Mon.		007 Jul	egistrar's S	Signature	100	itiv is						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BETTY COTTON 2007 12:13 p<sup>M</sup> LOU March 30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HARFORD CO. UPPER CHESAPEAKE MEDICAL CENTER BELATE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Months 1 □ M 2 XX Director 67 Sept 18 1939 MARYLAND 219-26-4416 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2XXNo Directo JOPPA MARYLAND HARFORD CO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 201 PHILADELPHIA ROAD 21085 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 20XNo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE N/A 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be t Department of Health and Mental I Important: If Item 27 is marked of BESSIE FITTS JAMES FITTS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Philadelphia Rd., Joppa, Maryland 21085 Charles R. Cotton Jr./Husband injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) OWINGS MILLS, MARYLAND GARRISON FOREST 04-6-07 21. Signature of Funeral Service License 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD,
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 arbaja 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consto, ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenc+(f) Examine requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death Ö 9□Unknown 9 Unknown signed by t d be detach Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 1 ☐ Yes 2 ☐ No al or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this Division or 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at Eccitifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) whe 30. Name and offdress of person who completed cause of death (Item 23a) (Type, Print) Wan 1308 2u 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

N

**Physician** 

1. Decedent's Name (First, Middle, Last)

9:20 AM WAYNE MARCH 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bon Secours Hospital Baltimore NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 73 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2 □ F Director 33 220-86-5857 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD NA Baltimore 1XiYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 4301 Elderone Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Never Married 2☐ Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NA NA Elementary/Secondary (0-12) College (1-4or 5+) 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wayne Chambers, Marlene Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Elderone Road Balto, MD 21229 Sharron Lennon-Sister injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or King Memorial Pk 4-4-2007 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East bla wan 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYLOI3 ALTERIUM DISSEMINATED /Medical Due to (or as a consequence of): **Examiner** MAQUIRED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1∐ Yes 2 1 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MARCH 29 D 23360 170. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECONES PATEZ, NDI SUDKIR. D 2000 W. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 3 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 🧶

Day

Year

3. Time of Death

2. Date of Death

Month

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Pay 2007 Month **Physician** March 28, 8:35 a. Irene A. Cogar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 € F Director April 3, 1930 West Virginia 235-46-4512 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1113 Evans Way 21205 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes XXNo Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Simmons Wirt Harper ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9303 Upwoods Lane Elaine Corazza (Daughter) Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopartion 与☐ Other (Specify) ⑤ □ Other (Specify) Garrison Forest V.A.Cem. 4/3/2007 Owings Mills, Md. 21. Signature of neral Service Licena 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland Approximate Interval Between Onset and Death Amarks The shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 0+ Due to (or as a consequence of): Sequentially list conditions, any leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off burlal-transi Exami Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical **Examiner** death certificate be executed

3/28/07-835AM

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

ed by the a detached f ate has been signed page 2 should be det certificate this After

Completed Be ů funeral Certification:

Medical

Division or Vital Records, al or Attends after death within 24 hours a

Registrar

Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed? Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

death (Item, 23a) (Type, Print) 30. Name and address of person who completed

W. Towsartown Bwd,

31. Date filed (Month, Day, Year) 3 200 APR 0

07-	02415	
Jill	Marie Conklin	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	7.0	2 U U / eg. No.	10403
Physicia		1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	ith	3 Time of Death
edical Exami	ner	Jill Marie Conklin	March 28		1904 hrs
		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location River Road & Furnace Avenue Linthicum Heights	of Death	4c. County of Death Anne Arundel	1
F		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	er 24Hrs 8 Date of B	rth(MM/DD/YYYY) 9 Bir	tholace (State or
Funeral Director		Months Days Hours	Min	Foreig	gn
	-	219-02-8345 1 M 2 N F 23 Yrs. With 23 N S N S N S N S N S N S N S N S N S N	APR 2	24 1983   <sup>co</sup>	untry) MD
any	ŀ	10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
nd show	_	MD Anne Arundel Glen Burnie			1 Yes 2 X No
arylau 8a-f s	Director	10e. Street and Number 10f. Zip Code		10g Citizen of What Cou	ntry?
the M a or 2 tified	ä	2004 Preston Road 21060		USA	
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status			ican Indian, 8lack,
death or iter	Fu	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican  1 Yes 2 X No	White, etc.		
ral",	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify or Dates:		Specify Whi	
hour	g E	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of 8usiness/	Industry
36 nin 72 than '	흺			3T / A	
d with	Completed	9 Unemployed  17. Father's Name (First, Middle, Last) 18. Mother	's Name (First, Middle,	N/A Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (	Gary Carr Gina	a Carlo		
21 nould id Me is man	의	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Num	nber or Rural Route Nu		, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		Gina Fowler - mother 2004 Preston Road		nie, MD 21	060
of Her		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	rown, State
Page ment tant:	I	4 Donation 5 Other Specify: Metro Crematory, Inc.	4/2/2007	Baltimore	, MD
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingry or other traumatic event, the Med		21. Signature of Funeral Service Licensee. Todd Dring  22. Name and Address of Facility Cremation Sol	ciety of Ma	ryland, Inc	.01000
Physician		239 Frederic.	K KOAO, BAI	rest, shock, or heart	21228 Approximate Interval
/Medical		failure. List only one cause on each line.			8etween Onset and Death
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, bb.			10
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
(ecords, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and rage 2 should be detached for use as the burial - transi		d			
60, ate be ex hysician e burial	Medical	UNPENDED			
376( ficate g phy s the b		IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopi	c pregnancy	23d. Date of deliver Month	y Day Year
Box 687  e death certific  the attending p  ed for use as th	iciai	past 12 months?  4 Pregnant at time of 5 Other (Specify)	o programay		
Bo e deat the at ed for	Physician/	9 Unknown			
P.O. es that the gened by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa		obacco use contribute to	the cause of death?
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by I director, page 2 should be detach.					utopsy findings available
ord aw reg as bee	Completed		24a Was		completion of cause of
Zec The la	ĕ		1 Yes		es 2 No
certifi ector,	Be (	25. Was case referred to medical examiner? Hospital: Inputient 2 FR/Outpatient 3 DOA Other4	<u>`                                    </u>		
f V; Physi er this	ပို	1 V Yes 2 No Prospiral 1 Inpatient 2 ER/Outpatient 3 DOA Office 4  27 Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work	Nursing Home 5	Residence 6  Othe	r: Scene
n of Inding Ph. h. After t	on:	1 Natural 5 Pending FOUND: 1 Yes 2	. I Inknown	now injury occurred	
Division of Vital Records, and or Attending Physician: The law required in Director: After this certificate has been sided in by the funeral director, page 2 should be	cat	2 Accident Investigation Mar 28, 2007 1830 hrs		Street and Number or Ru	ural Route Number, City
Div talor rs afte	Certification:	Suicide  4 Homicide  Gould not be determined  (Specify) Woods	or Town.		
Hospi 24 hou Funer rely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	ace, and due to the cau	se(s) and manner as stat	ed
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ccurred at the time, date	and place, and due to the	ne cause(s)
F 3 F 3	Me	29b. Signature and title of certifier 29c. License number		29d Date signed (Mo	nth, Day, Year)
1		O.C.M.E.		March 29, 2007	
		30. Name and address of person who completed cause of death (Item 23a)	21201		
1		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	7 2 1201		
St Regis	tate trar	31. Date filed (Month, Day, Year)  Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-02223 State of Maryland / Department of Health and Mental Hygiene Leroy Carpenter 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ 2352 hrs March 22, 2007 Medical Examiner Leroy Chavis Carpenter 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 1944 Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Director Country) Yrs 1 X M 01 MD 218-40-4429 -66 80 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No 28a-f show Baltimore NA MD hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3713 Overview Road II.S.A Funeral 13. Was Decedent of Hispanic Ongin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 1 Yes 2 X No specify: es. Give Year Specify: Black 3 Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ages I and 2 should be filed within 72 h
nt of Health and Mental Hygiene.

t: If item 27 is marked other than "n
other traumatic event, the Medical E 72.1 Baltimore, MD 21215-0036 12th grade 4yrs City Planner Baltimore City 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Edgar J. Carpenter
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

MD 21117 Florence Bellon Shelley Carpenter-Daughter 9315 Leigh Choice Owings 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Pages 1 1 X Burial 2 Cremation 3 Removal from State 4/2/07 Garrison Forest Velt Owings Mills, Md partment o 4 Donation 5 Other Specify 21. Signalure of Funeral Service Licensee March F/H West 4300 Wabash Ave. 21215 Approximate Interval Baltimore, Md 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a Complications of Partial Small Bowel Obstruction Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Adhesions Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Ceuse Examine c. Right Hemicolectomy (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Lest d. Colon Cancer Physician/Medical physician the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 V Unknown Hypertensive Atherosclerotic Cardiovascular Disease; Diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 V Yes 2 No e Hospital or Attending Physician: 124 hours after death. 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner's Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 this ဥ 1 ✔ Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 🗸 Natural 1 Yes 2 Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 24, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

**∮** State

Registrar

Carol Allan, MD

Year) 32. Registrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ELVERA Month **Physician** CRISPENS 08.38 PM 03 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Nursing Home Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months | Days 1 □ M 2 🔭 F Hours Director 218-05-1254 Feb 14, 1921 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director |MD|Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1011 Linden Avenue 21227 Funeral A. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4gr 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Joseph Ba**b**ka Viola Krofcik 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth L. Crispens, Sr./Husband 1011 Linden Avenue Arbutus Md 21227

| 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cefficiery, crematory or other place) Burial 2 □ Cremation 3 ☐Removal from State Cedar Hill Cemetery 3-30-2007 Brooklyn, Maryland 4 Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ERMINAL **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home Hospital: 1 Yes 2 No 1 🔲 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064533 MI 03 - 27 - 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE GERIATRIC CENTER AND ITOSPITME 2434 W. SEREDENE AVE. BATIMORE, MD BABATUNDE

DHMH 17 Rev 1/2001

State

Registrar

AJANI

32. Regatrar's Signature

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M.

3

07-02448 Pamela Collins

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		Ce	rtificate o	f Death					Reg. I	No.			
	Physicia		Decedent's Name (First, Middle	,Last)						2	Date of D	eath)			3. Time of Death	$\neg$
adic	al Exami		Pamela	C	ollins						Month March 3	30. 20			1635 hrs	
			Pamela  4a. Facility Name (if not institution	, give street and	number)		4b. City, To	wn, or Lo	ocation of			,	4c. County o	f Death	-	$\dashv$
			134 Konrad-Morgan W				Lothian						Anne Aru	ındel		
	Euroral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9.									9. Birth	place (State or	ᅱ		
	Funeral Director						Months	Days	Hours	Min.				Foreign		
	Director	L		1 M 2 X F	51	Yrs	S.				гер	ο,	1956	Cou	ntry) VA	_
			Usual Residence of Decedent		140 00										10d. Inside City Lim	ito
	A Bu	- 1	10a. State 10b. County		Tuc. City	, Town or Loca	tion									
	and sho	히	Maryland Anne A	Arundel		Loth	ian								1 Yes 2 X	NO
	laryl	ct	10e. Street and Number				10f. Zip C	ode				10g.	Citizen of Wh	at Count	ry?	
	death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	134 Konrad	Morgan	Way		20	711				Ιu	nited	Stat	es	
	s 23s		11. Marital Status		ecedent Ever in U	.S. 13. Wa	as Decedent	of Hispa	anic Drigi	in? (Spec	cify Yes or	No-	14. Race	Americ	an Indian, Black,	$\neg$
	item	Funeral	1 Never Married 2 Ma	illed _	Forces?	If Y	es, specify	Cuban, I	Mexican,	Puerto R	ican, etc.)		White	etc.		
	ter de												White			
	rs af ural min	٥	15. Decedent's Education (Spec	or Dates:		16a. Decede				ind of wo	rk done	16	b. Kind of Bus			$\dashv$
	"nat	Completed	Elementary/Secondary (0-12)		(1-4 or 5+)		nost of worki									
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0	with giene her t	팅	17. Father's Name (First, Middle,	Last)		Admi	.1115(11					le Maio	den Surname)	141	OOVETIMET	-
5.	filed H Hy H et al							- 1		,				+		
21215-0036	d be fenta narke	o Be	George T. Mulligan Phyllis Warmant  19a Informant's Name/Relationship (Type, Print ) 19b Mailing Address (Street and Number or Rural Route Number, City or Town. S											Zin Code)	_	
	shoul ind N is m	ř														
Σ	I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Ex miner must be notified at once		James Mulligan (Brother) 1623 Dartmoor Drive, Huntingtown, MD										City or T	own State	-	
٩	s l a g He if He		20a. Method of Disposition  1 XX Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Apr 9, 200 20c. Location - City											Oity Oi 1	own, otate	
0	Pages nent of ant: If or other		4 Donation 5 Other Sp		Ma	ryland	Veter	ans	Ceme	tery			Che1te	nham	, Marylar	ıd
altimore, MD	permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Ex. miner	1	21. Sign tre of Fineral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc.											nc	663301d	
ä	E E E	Vii 18	MANUE	1/1	100153		Alexa	ndri	a Fe	rrv	Road.	C1	inton.	MD	20735	
Р	hysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											irt	Approximate Inter-	
	/Medical	SL 3	failure. List only one cause on each line.  Immediate Cause (Final disease a Hypertensive Atherpsclerptic Cardiovascular Disease											Between Onset at Death	)IQ	
[	xaminer		Immediate Cause (Final disease or condition resulting in death)	_	s a consequence of		10 40 50010	AT 15150						_		_
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		ē	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence o	of):										
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.												
1	d sit	xa	events resulting in death) Last	Due to (or a	s a consequence of	of):										
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	ial al	n/Medical	UNPENDED	AMENDE	D											
8760	icate be er physiciar the burial	₩.	IF FEMALE:		s, outcome of preg	gnancy							23d. Date of			
Ü	ertifi ding e as	an	23b. Was decedent pregnant in the past 12 months?		e birth				Ectopic	pregnan	су		Month	Di	ay Year	
Box	death certi ne attendin I for use a	sic	1 Yes 2 No 9 Unk		egnant at time of d	eath 5 C	ther (Speci	fy)								
ď	re de hed f	Physicia	Part II. Other significant conditi	9 011	known	anni litin n in the		ou oo oi	on in Do	et l	23e D	id toba	cco use contri	bute to t	ne cause of death?	
٥	res that the death certifications signed by the attending be detached for use as	by F		ons continuating	g to death but not	resulting in the	undenying	ause gn	veri in i a		3 -		_	_	ably 4 Unknow	νn
	ires sigr d be	ρ	Chronic Alcoholism									_				
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2	e law te has ge 2 s	Ē			-							erforme es 2		eath?	2 No	
ď	tian: The certificate ector, page		25. Was case referred to medical				21	S Place o	of Death (	Check or				•		—
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of Wital Records	Physi er this ral dir	ြို	1 ✓ Yes 2 No 27. Manner of Death	28a D:	ate of Injury	28b. Time of			at Work				v injury occum	_		
(	<b>-</b> = . ~ ≥	ä	1 Natural	(Mo	onth, Day,Year)	200. 11110 0	,,	_	es 2	- 1			,			
Division	or Attenerater death	ă;	relic	stigation I							2011	(0)	and the same of	O	al Route Number, C	71417
	or A after Dire	≝		d not be	lace of Injury - At I	home, farm, str	eet, factory,	office bu	uilding, etc	C. 2		on (Stre n, Stat		er or Rui	al Route Number, C	ally
2	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifiely filled in by the funeral director.	Certification:	4 Homicide	mined (Spec												_
	표 것 또 의		29a. Certifier 1 Certifying Pt	nysician: To the	best of my knowle	dge, death occi	urred at the	time, dat	te and pla	ice, and c	lue to the	cause(s	s) and manner	as state	d	
	To the within 7 To the complete	Medical	one) Medical Exam	miner:Dn the bas and mann	sis of examination er stated.	and/or investig	ation, in my	opinion,	death oc	curred at	the time, c					
	F × F 8	ğ	29b. Signature and title of certifie				29c.	License	number			2	9d. Date sign	ed (Mon	th, Day, Year)	
			(() ( Son	LRAIN	)			O.C.N	ΛE.				March 31,	2007		
	/			V-1/V	/											
			30. Name and address of person	who completed o	ause of death (Ite	m 23a)										
	16		30. Name and address of person Larpn Locke MD. A		ause of death (Itelical Examiner		n Street,	Baltim	ndre, M	D 2120	)1					
	I	tate	Laron Locke MD. A	ssistant Med		111 Pen	n Street,	Baltim	nore, M	D 2120	)1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	ico Guitic	•		- For State Registrar	Certificate o			eg. No.	/ 1040/			
	Physi		n/	1. Decedent's Name (First, Middle,Last)			2. Date of Dea Month		3. Time of Death			
Vled	ical Exa	min			Curtis		March 29	, 2007	1700 hrs			
			H	4a. Facility Name (if not institution, give street and Suburban Hospital	number)	4b. City, Town, or Location Bethesda	of Death	4c. County of Deat Montgomery	1			
	F		4	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or					
	Funer Directo			577 38 5295 XXM 2 1		Months Days Hou	to Min	Forei				
	any		-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits			
	*	انه	راح	Virginia Loudoun	Lee	sburg			1 Yes 2 XXNo			
	Maryland 28a-f show	at on	$\sim$ L	10e. Street and Number		10f. Zip Code	1	log Citizen of What Cou	ntry?			
	the M	= 1	United Sta	tes								
	0036 within 72 hours after death with the Maryland gjene. her than "natural", or items 23a or 28a-f she	ust be n	Funeral		Forces?	as Decedent of Hispanic Or Yes, specify Cuban, Mexica		14. Race - Amer White, etc.	ican Indian, Black,			
	after o	힌	교	3 Widowed 4 Divorced If Yes, Give or Dates:	Year 1	Yes 2X No specif	y:	Specify:	White			
	nours	xam		15. Decedent's Education (Specify only highest g	during r	ent's Usual Occupation (Given most of working life. DO NO		16b. Kind of Business/	Industry			
9	136 hin 72 l e. than "	ical	bet		e (1-4 or 5+)	П			ros Furniture			
	00.   with grene her t	Med	Completed	12   17. Father's Name (First, Middle, Last)	5 Busin	less Ex.	er's Name (First, Middle,		<del>Brols Funitu</del> r			
	21215-0036 ould be filed within 7 Mental Hygiene.	f,	Be C	Harry Lee Curti	Q		Rena I. Co					
	212 ould be Menta marke	c eve		19a. Informant's Name/Relationship (Type, Print )		ng Address (Street and Nu			e, Zip Code)			
	MD id 2 sho lith and m 27 is	umat		Hilda Curtis (Wife)	4138	3 Raspberry sition (Name of cemetery,	Drive, Lees	burg, Va 20	176			
	ore, MD 3 ges 1 and 2 shot of Health and 1 If item 27 is	r ta		20a. Method of Disposition  1 Burial 2 X Cremation 3 Remova			Date	20c. Location - City or	Town, State			
	Baltimore, permit. Pages I a: Department of He Important: If ite	or other traumatic event, the Medical Examin		1 Burial 2 X Cremation 3 Remova 4 Donation 5 Other Specify:	i ii Oili State	tory April	d. 2007	Clinton,	MD			
	Baltimo permit. Page Department o Important:	ury o	t	21. Signature of Funeral Service Little sec	22.	Name and Address of Facil	tyLee Funera	1 Home, Inc	6633 01d			
ı	<b>©</b> 50 T	E	1		00153 A1	exandria Fer	ry Road, Cl	inton, MD				
	Physicia			23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.	at caused the death. Do not enter	the mode of dying, such as	cardiac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and			
	Medic Examin		1		Tamponade				Death			
			-	or condition resulting in death)  Due to (or a	is a consequence of):							
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	387 rtifica ing pl	as the		23b. Was decedent pregnant in the past 12 months?	re birth 2 F	etal death 3 Ector	oic pregnancy	Month	Day Year			
	Box 687 e death certific the attending p	for use as	Sici	4 Pr		Other (Specify)						
	he de	ped f	Physician/		known g to death but not resulting in the	underlying cause given in	Part I. 23e. Did t	obacco use contribute to	the cause of death?			
	, <b>P.O</b> . ires that th	deta	ठ	Acute Hip Fracture	g to doddin but his resulting in the	and only in great and a given in the		es 2 No 3 Pro	bably 4 🗸 Unknown			
	rds, requires been sig	should be	Completed	, today , marking			24a. Was		utopsy findings available			
	Sore law re has be	2 shc	餇					ormed? death?	completion of cause of			
	tal Recian: The certificate	, page	إق				1 Yes	2 No 1 Y	es 2 No			
	Division of Vital Records, rat or Attending Physician: The law requirrers after death at Director: After this certificate has been si	ector	Be	25. Was case referred to medical examiner? Hospital: 1	Inpatient 2 ER/Outpatie		Nursing Home 5	Residence 6 Othe	ar:			
	Physi er this	eral di	의	Tes Z No	ate of Injury 28b. Time of			how injury occurred				
	on of nding Pl th r: After	e func	<u>=</u>	1 Natural 5 Dading Feb.	onth, Day Year) 1430 hrs	1 Yes 2	✓ <sub>No</sub> Subject fell					
	isior Attender death	by th	igat	2 Accident investigation 28e. F	25/2007 Lace of Injury - At home, farm, str	eet, factory, office building,		(Street and Number or R	ural Route Number, City			
	Divisor A bours after neral Dire	filled in	Certification:	3 Suicide 6 Could not be determined (Spec	ify) Restaurant		or Town, Route 3, Boy	State) vie, MD				
	Hospita 24 hours Funeral	e c		29a. Certifier 1 Certifying Physician: To the	best of my knowledge, death occ	urred at the time, date and	place, and due to the cau	ise(s) and manner as sta	ted.			
	Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending g	completely	Medical	one) 2 Medical Examiner: On the ba	sis of examination and/or investig	ation, in my opinion, death	occurred at the time, date	e and place, and due to t	he cause(s)			
	¥≅∓ L	20	₽	29b. Signature and title of certifier	0	29c. License numb	er	29d. Date signed (Me				
				Pote Gran :-	. Kallal m	O.C.M.E.		March 31, 2007				
	inxl		-	30. Name and address of person who completed	cause of death (Item 23a)							
	IV			Patricia Aronica-Pollak MD. Ass	istant Medical Examiner	111 Penn Street, E	Baltimore, MD 2120	)1				
			ate		. Registrar's Signature	80						
	Reg	gist	άľ	ADD A 3 2007_ A	allines of the first the same	-						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Joseph Clarkson, Jr. March 20 2007 9:36 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days **½** M 2□ F Months 215-03-6490 Sept. 8 1912 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2X No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3 Orchard Rd. 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Salesman Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Clarkson, Sr. Agnes Mann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally C. Kauffman/daughter 2970 Baldwin Mill Rd., Baldwin, MD 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Donation 5 Other (Specify) 3 ☐Removal from State Vernon Methodist Ch. Cem. 3/24/07 White Hall, MD Signature | Funeral Service License Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately Appr 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final following Complications Fracture disease or condition resulting in death) NECKS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementio 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

Director

28a-f show

rai", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23s any lighty or other traumatic event, the Medical Examiner must one.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be ပ

/Medical

physician and s the burial-tran as attending plant of the seas signed by the a rector, page 2 s this

The law requires that the death certificate be executed

or Attending Physician;

Division or Vital Records, P.O. Box 68766

Examine Physician/Medical Completed by Be 0 Certification: after death.

i Director: /

25. Was case referred to medical examiner?

123 Yes 2 No 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier

6 ☐ Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) Murch 3 2007 28b. Time of Injury

28c. Injury at Work? EARLY 1 ☐ Yes Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 AOther (Specify) WOSPLA 28d. Describe how injury occurred

tell or Slid From wheelchar

28f. Location (Street and Number or Rural Route Number, City or Town, State) Nuncing Home

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29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

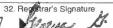
Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles un 6701

and manner stated

Ba) (Type, Print) Navles ST TOWSUN MD Z1204

State Registrar 31. Date filed (Month, Day, Year) 3 APR 0



within 24 hours aft

To the Funeral Di

completely filled in To the Hospitai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 2866 4-3-07 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2:34 CURRIER Georgiana Currier 2007 CTEOREHANNA April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryland NA Baltimore Medical Center University Birthplace (State or Foreign Country) (In yrs. last birthday, 79 Yrs. Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 M X F NJ 151-18-0861 -20 - 1927Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director GLEN BURNIE ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 133 SOUTH MEADOW DR. 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE ģ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE H. CLAYTON FLORENCE SAGURTON CLAYTON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SOUTH MEADOW DR.; GLEN BURNIE, MD 21060 MR. LEE CURRIER/ HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) APRIL 3 20a. Method of Disposition 20c. Location - City or Town, State STEVENSVILLE MD 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION | 2007 21. Signature of Foreral Service Licensee 22. Name and Address of Facility 1 SECOND AVE. SW, SINGLETON FUNERAL HOME, PA; GLEN BURNIE, MD 21061 M01411 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ST elevated Myocardial Infarction 11 Days **Physician** /Medical Due to (or as a consequence of): Examiner .ymphoma unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, certificate has been signed by the attending physiclan rector, page 2 should be detached for use as the burial pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 卢 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier P21187 2007

State Registrar

DHMH 17 Rev 1/2001

KOBIN ENCK

31. Date filed (Month, Day, Year)

APR 03

Baltimore,

MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

22 S. Greene St.

32. gatrar's Signature

For Amend #29d Per PhyG866 4/05/07 JH Certificate of Death

Reg. No. 1 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 30, žearo7 Physician Wilhelmina Cumbest Α. /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Baltimore Towson 8. Date of Birth (Month, Day, Year)
Feb. 12, 1 5. Social Security Number 216 – 28 – 6040 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 □ M 2 🕱 F Hours 89 Director 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Md. Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21120 USA 23 English Saddle Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines any any 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Reinsfelter Stephen Albaugh 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 English Saddle Ct. Parkton, Md. 21120 Mr. James Cumbest, Jr./ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Pk. 4-4-07 Parkville, Md. 21. Signature of Paneral Service Licensee 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner SEPSIS HOURS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed END STAGE C.O.P.D. 1-2YEARS Due to (or as a consequence of): burial Box 68760; physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CHRONIC RENAL FAILURE, TYPE II DIABETES MELLITUS Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes □ No NON Q WAVE MYOCARDIAL INFARCTION autopsy page perform cate Division or Vital 1∐ Yes PULMONARY HYPENTENSIVE HYPERTENSION director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury thours after death.

uneral Director: Af
ely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory filled in by 4 ☐ Homicide 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) DØØ27693 3/30/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12:27AM

1 ☐Yes 2 No

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Year

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31. Date filed (Month, Day, Year)

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MARYLAND

30. Name and address of person who completed dause of death (Item 23a) (Type, Print) M. D.

7601

32. Registrar's Signature

College

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Gladys E. Duncan 07:35 M 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Good Samaritan Hospital Baltimore NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11-19-1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2X F Yrs. Director 80 S.C. <u>219-28-5692</u> Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f ahow The Madical Examiner must be notified at 1 Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Amed Forces? 21202 S Funeral 110 Central Α Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If itam 27 is marked other than "natural", or Ite. 1 Never Married 2 Married 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ρ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) llth grade Private Duty Nurse Hospital itam 27 is marked other other traumatic evant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edd Brockington P Emma Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eddie J. Duncan -Son 1232 Ashland Avenue Balto, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of Important: If any injury or once. King Memorial PK 3/31/07 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East MD<sup>21202</sup> Bla 1101 E. North Avenue Balto, an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) sictific A /Medical Due to (or as a consequence of). Examiner my o cordial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ted burial-transit that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of D ath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred al or Attanding F s after death. 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To tha within 2 To tha 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

il

State

2 560/ 32. Registrar's Signature

Teresa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mun

APR 0 3 2007

31. Date filed (Month, Day, Year)

40059540

Raven B.Wd. BACTIMITE MD Z1239

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Health and Mental Hygiene
			1 - State Registrar Certificate of Death Reg. No. 2007 104 2
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 3. Time of Death
	/Medic	al	Arbutus vober April 1 2007 405PM
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Raftimove
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		235-38-2081  1 M 2 X F  90  Yrs. Months Days Hours Min. (Month, Day, Year)  JUL 14 1916  WV
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
	a-f sh	tor	MD Baltimore Gwynn Oak 1 □Yes 2 🕅 No
	ith the	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	s 23a nust t	era	4012 Buckingham Road 21207 USA
<b>'</b>	fter de r Item iner r	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  1 □ Yes 2 ☑ No  1 □ Yes 2 ☑ No  1 □ Yes 2 ☑ No
ဗ္ဗ	ours a ral', o Exarr	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 ☑ No Specify: Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Sive kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry (Sive kind of work done during most of working life. DO NOT use retired)
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b	be filed stal Hyg ed other event, i	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland	should be ind Mental imarked o	Jo L	N. E. Marrical Blanche Cutlip
Mai	0 0 0 0		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Patsy J. Daniello – daughter  1124 Walker Avenue, Baltimore, MD 21239
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
altimore,	Pages nent of I ant: If ite		1 Burial 2 Coremation 3 Removal from State 4 Donation 5 Other (Specify)  Metro Crematory, Inc. 4/3/2007 Baltimore, MD
Balt	permit. Pages Department of Important: If it any Injury or c once,		21. Signature of Funeral Service Licensee H. Williams  22. Name and Address of Facility Cremation Society of Maryland, Inc.
	20 = 6 0	-	299 Frederick Road, Baltimore, MD 21228
t e j	Physician	9 D	shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)  a. OMMAN CGIVEO VEWTONIG AQYS  Due to (or as a consequence of):
	Examiner	_	Sequentially list conditions.
	nsit	Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
o,	ate be executed nysician and he burial-transit		that initiated events ' c C Due to (or as a consequence of):
8/60	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	lical	d
RG X	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE: 23h Was decedent prograph 23c. If yes, outcome pf pregnancy
ROX POX	death e atten d for u	ician	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  1 Pregnant at time of death 5 Other (specify)  Month Day Year
J O	w requires that the d been signed by the should be detached	hys	9 □ Unknown 9 □ Unknown
	ires th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Records,		eted	Covigestive near tailure 1 yes 2 No 3 probably 4 Dunknown
	sician: The law significate has birector, page 2 st	Completed by	24a. Was an autopsy sindings available prior to completion of cause of death?  1  Yes 2 ☑ No 1  Yes 2 ☑ No
	ian: I	Be	25. Was case referred to medical examiner?  26. Place of Death Check only one)
or <	hysic this ce	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
SION (	nding Physician: th. : After this certifica s funeral director, p	ii iii	27. Magner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 1 ☑ Natural 5 ☐ Pending investigation 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 1 ☐ Yes 2 ☐ No
N N	Attend r death ector: by the	lical	3 Suicide 6 Could not be determined 28e. Place of injury. At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
5	ital or rs afte ral Dir led in	Certification:	City or Town, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification properties of the funeral director, to the funeral director.	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the Comple	Me	29b. Signature land title gr certifier 29c. License number 29d. Date signed (Month, Day, Year)
			Chrufine Kajuhi 62912 April 1 2007
	)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P	Stat	e	31. Date filed (Month, Day, Year) 3. Registrar's Signature
	Registra	ır	APR 0 3 2007 Basica D. 19

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 April 1, **Physician** Albert Robert Davis, Sr. 10:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year)
July 2,1921 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 215-18-9434 85 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and it filem 27 is marked other than "natural", or items 23a or 28a-f show ant; if item 27 is marked other than "natural", or items 25a be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√2 No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502 Ivy Hill Road 21030 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced WII 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manager Maritime Steamship 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Davis Julia Gawrys ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1502 Ivy Hill Road, Cockeysville, MD 21030 Concetta E. Davis, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o **IX** Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Cons. 4/5/2007 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland MO1113 22. Name and Address of Facility Brian T. Chisholm Funeral Services of 21. Signature of Funeral Service Licensee Mula 14 Dulaney Valley, P.A. 200 Padonia Road, Timonium, MD 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the pseas shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and --The law requires that the death certificate be executed Due to (or as a consequence of) burial Box 68760. Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. by the a 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by metastases 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 70 28a. Date of Injury (Month, Day Year) 27. Manner of D. ath 1 D.Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: Af 1 □ Yes 2 □ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year)

12+1

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 3 - 2007

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD/555 W. Towsertown Blud Majorar's Signature 200

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	e Maryland 3e-f ehow
	ter death with II Iteme 23a or 2 Der must be n
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or Iteme 23s or 28e-f ehow eny Injury or other traumatic event, the Madical Examinar must be notified at
 ryland 2	permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Importent: if Item 27 is marked other thar eny Injury or other traumatic event, than
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80.	Physicia /Medica Examine

nding physician and use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. I signed by Division of Vital Records. certificate To the Hospital or Attending Physician: After this certification funeral director. death. Director: / within 24 hours after d

To the Funerel Direct
completely filled in by ģ

For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month **Physician** March 30, 2007 9:40 A Frederick John Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 111 Glenwood Rd. Harford Bel Air If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 2□ F Months Director 93 Oct. 30, 1913 Maryland 216-03-8112 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 1 ☐ Yes 2X No Director Maryland Harford Bel Air 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 21014 111 Glenwood Rd. USA Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Yes 2€ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Banking 10 Vice President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Augusta Karolus Fred (nmn) Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine Davis/Wife 111 Glenwood Rd., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3 ∏Removoval from State 1 Burial 2 Crema 4-02-07 Hilltop Service Corp Towson, Maryland 4 Donation 5 Oth McComas Funeral Home, P. A. 21. Sign once. 50 West Broadway, Bel Air, Maryland 21014
shock, or heart failure. List only one cause on each line.

Approximately a few files. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVASCULAR ATherosclers to years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) ို 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified d35522 MARCH 30,2007 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) NORTH BELAIR MARYLAND 2/014 Avenue 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

Registrar

Ot

2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician March 28, Georgia Mae Dell 2007 12:55P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Bayview Medical Center N/A8. Date of Birth (Month, Day, Year, Tuly 20, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M XX Months Days Hours 266-44-7665 72 1934 Director Illinois Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BAltimore MD N/ADirector 1XXes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 6005 Arizona Avenue 21206 U.S.A. an "natural", or Items 23a Medical Examiner must Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: \$ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use relied)
Underwriter 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M uth and Mental Hygiene.

27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) Travelers Ins. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany or other traumatic event Be Edward King Marion Mannix ၉ 19a. Informant's Name/Relationship (Type. Print)
Ronald Dell (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6005 Arizona Avenue Balto, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4/2/2007 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home,
3637 Fails Road Balto, MD 21211 21. Signature of Functal Service Licens 23a. Part1. En er the disease, o con shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Lung Disease **Physician** hranic disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1☐ Yes 1 ☐ Yes 2 ☐ No 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after death Puneral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00036343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud White Marsh, MD 21236 10 4920 WANDA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 03

State Registrar Jeorge

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

APR 0

32. Registrar's Signature

March 31, 2007

3900 Loch Raven Boulevard, Battimore, MD 21218

			For State Registrar	State of Maryla		artment of H rtificate of L		·	giene 0 0	7 10417
I	Physici		Decedent's Name (First, Middle, Last)     William	Frederick	Doug1a	as		2. Date of De March		3. Time of Death 6:45 p.m
9	/Medio Examin		4a. Facility Name (If not institution, give stre Westminster Nurs	et and number) ing Home		4b. City, Town, or Westmi	Location of Death		4c. County o	
	Funeral Director		5. Social Security Number 216-07-1650 6. Sex	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da June	th, Year) 919	9. Birthplace (State or Foreign Country) Maryland
	land ow at		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits
	the Marylar 28a-f show notified at	Director	Md. Baltimore	. Sr	parks					1 □Yes 2 █ <b>X</b> No
	ath with the 23a or 2 ust be no		15907 York Rd.			10f. Zip Code	1152		10g. Citizen of Wh	uat Country? USA
9200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 🗷 Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 → No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		American Indian, White, etc. White
15-(	in 72 h n "natu Medical	plete	15. Decedent's Educati (Specify only highest grade co		16a. Deced (Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	ation <i>furing most of workii</i> )	ng	16b. Kind of Busi	ness/Industry
212	ed with ygiene ner tha ıt, the l	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Manı	ufacturer	·		Paint &	
land	uld be fil Aental H rked ott tic even	To Be	17. Father's Name (First, Middle, Last)  James T. Douglas	, Sr.				(First, Middle, eroni	Maiden Surname)	)
Baltimore, Maryland 21215-0036	and 2 sho alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Susan Douglas/ Dau				and Number or Rura d. Sparks			tate, Zip Code)
nore	ages 1 and of He t: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	-	sition (Name of natory or other place Service C	θ)	-07	20c. Location - C	
Baltir	Departme mportan iny injur		21. Signature of Funeral Service Licensee				wson Fune rk Rd. To			
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the dea						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	Enas	_	unal bi			Onset and Death
B	Examiner		Sequentially list conditions, b. –			,				
16	outed Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a conse	quence of:					
68760,	ificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conse	equence of):					
	ertificat fing phy se as the	/Medi	IF FEMALE:	lf						
P.O. Box	The law requires that the death certil te has been signed by the attending rage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome pf pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	tal death 3	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of Month	
rds, F	quires tha	þ	Part II. Other significant conditions contrib	uting to death but not re	esulting in the un	derlying cause give	n in Part I.			ute to the cause of death?  ☐ Probably 4 ☐Unknown
Division or Vital Records,		Completed						24a. Was autop	rmed? prid	ere autopsy findings available or to completion of cause of ath?  JYes 2 \sum No
Vita	rsician: s certific lirector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hosp	pital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient	Othe	26. Place of Death	(Check only o	ne)	
n of	Attending Physician: The Ir death. ector: After this certificate he by the funeral director, page	on: To		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			dence 6 Other now injury occurred	· · · · · · · · · · · · · · · · · · ·
visio	Atten r deatt ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Spec	home, farm, stre		'es 2 □ No 2	8f. Location (S City or Tow	Street and Number	or Rural Route Number,
Ö	Hospital or 4 hours afte Funeral Dir tely filled in	Cer	29a. Certifier 1 Certifying Physicia	an: To the best of my kn	nowledge, death	occurred at the tim	e, date and place a	and due to the	cause(s) and mann	nar as stated
	To the Ho within 24 h To the Ful completely	Medical	one) 2 Medical Examiner	On the basis of examin and manner stated.	nation and/or inv	estigation, in my op	pinion, death occurre	ed at the time,	date and place, an	d due to the cause(s)
	with		29b. Signature and title of certifier	Maden		29c. License	059943	1	29d. Date signed (	2, 2007
	2	-	30. Name and address of person who come	eted cause of death (Ite	em 23a) (Type, F	Print)	307 V	25)m11	7.1	0 21157
	Sta Registra		31. Date filed (Month, Day, Year) APR 0 3 2007	293 37 32. Registrar's Sign	nature Local	E)		7	<u> </u>	100 - 113/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23e per doc 2866 4-3-07 eath and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 2007 Margaret Johnston Engelbrecht 9:36 ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caton Manor Nursing Home Baltimore N/A8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days 1 M 2 F 86 Yrs Director Feb. 10, 1921 California 573-24-5993 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Race - American Indian, 21090 by Funeral 378 Centerhill Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural" or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Clarke Johnston Florence Watkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 378 Centerhill Avenue Linthicum MD 21090
pe of Disposition (Name of Date 20c. Location - City or Mary Jordan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crest Lawn Memorial 03-30-2007 Sykesville, M. Gardens
22, Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd Arbutus MD 21227 20c. Location - City or Town, State 20a. Method of Disposition TX Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Maryland 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Vicenses r it instituted the Yeath. In not enter the mode of dying, such as cardiac or respiratory arrest, le cluse on each line. 23a. Part. Enter the disease, or companies shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT Few M.NTH /Medical Due to (or as a consequence of): Examiner FEW MINTHS HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of redifier MI 10062634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 COLUMBIA MATEGN A. AWAN 10802 HICKURY

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State Registrar 31. Date filed (Month, Day, Year)

32. Reditrar's Signature

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** VIN /Medical 2007 Facility Name (If not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Social Security Number last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 1 F Hours **Director** BALTIMORE, MC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 'natural', or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No OSP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Balt. Co Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If item 27 is marked other tha any injury or other traumatic events. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 19a. Informant's Name/Relationship (Type. Print) Plea sant P 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □R 4 □Donation 5 □ Other (Specify) 3 □Removal from State BALTIMORE, ark Concern 4-2-07 DALTIMORE, MD 212. Name and Address of facility 3 New Jot Dr., Forest HII, MD 2125 oud on Your 21. Signature of Funeral/Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** minutes ardiac /Medical Due to (or as a consequence of): Examiner pertensidi Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician for use as the buriz Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed es 2 or Vital Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) awass 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 3718 NORRISVILLE RO, SUITEC JARRETTSVILLE MD 2/054 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

07-02307 Larry Foster Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2007 10420 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 25, 2007 Medical Examiner 2309 hrs Larry Foster 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Hours Director Days 217-50-0450 60 7-30-1946 MD 1 X M 2 F Country) Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. Count 10d. Inside City Limits or items 23a or 28a-f shormust be notified at once. 28a-f shov MDBaltimore 1 X Yes 2 No after death with the Maryland 10e. Street and Number 10g Citizen of What Country? Of, Zip Code 1200 N. Caroline Street Aptl R 21203 USA ö Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.: 1 X Never Married White, etc. Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify. Specify: Black ۾ Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natur: or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ted during most of working life. DO NOT use retired) NA Elementary/Secondary (0-12) College (1-4 or 5+) Complet 8th grade NΑ 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Howard Hood Marie Foster 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 N. Caroline Street Apt 1R BALTO, MD Yvonne L. Wall - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Carmel Cemetery 4-2-2007 Balto, Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East ladi Balto, MD 21202 1101 E. North Avenue ou 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** failure. List only one cause on each line Between Onset and /Medical Death Acute ethanol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical X UNPENDED signed by the attending physician be detached for use as the burial <sup>AMENDED</sup>, PII, 27, 28a-f, perME, g866, 4/6/07 TT IF FEMALE: 23d. Date of delivery 23c, If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic cardiovascular disease Completed of Vital Records, has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? certificate page ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) മ examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other<sub>4</sub> DOA this Nursing Home 5 Residence 6 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Natural I Director: ed in by the f 5 Pending 1 Yes 2 X No Fnd 3/25/2007 Fnd 10:44 pm 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) determined (Specify) house 1200 N. Caroline St. Baltimore. MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 26, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**ÖRIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** March Moneake a Nya 5:06 PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Iniversity of Maryland Medical Center Date of Birth (Month, Day, Year) 3 20-2007 Birthplace (State or Foreign Country) **Funeral** Months Days Director NA MDUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified 1 Yes 2 No MD NA Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 412 N. Milton 21224 23a Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Never Married 2☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates: natural Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NA (Give kind of work done during most of working III.) Inc. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DeLontae M. Smith မ Sherry S. Fowlkes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Fowlkes - Mother 412 N. Milton Avenue Balto, MD 21224 : If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any Injury or once, Zion Cemetery | 4-2-2007 | Lansdown, MD Μt 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue F/H East MD 21202 Ø Wans 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Enterocolitis recrotizino disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; ₽ 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, Rm N5W68, Baltimore, MS 21201

State Registrar

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31. Date filed (Month, Day, Year)

Hamuyide.

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Registrar's Signature

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			1- For State of Maryland / Department of Health Certificate of Deal			ene 007	10422
	·春 博 · 俊	d <sub>N</sub>	Decedent's Name (First, Middle, Last)	2	2. Date of Death		3. Time of Death
B	Physici /Medio		merbert ford in	M	Month Sarch 26	,2007 Year	12:14A M
	Examir			tion of Death		4c. County of Deat	h
			Washington Adventist Hospital Takoma Pari	rk		Montgomer	су
	Funeral		Months Dave House	nder 24 Hrs. g	B. Date of Birth	9. Birti	nplace (State or Foreign untry) 1Sylvania
	Director		197-48-2809 13X 201 31 Yrs.	M	(Month Day, )	1956 Peni	isýlvania
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl f ehc	5					1 ∰Yes 2 □ No
	28a	rect	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Co	untry?
	3a of	ā	5201 Connecticut Avenue, N.W. #917 20015			United Sta	Ť
	ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	ic Origin? (Speci		14. Race - Ame	
9	or to	Fui	Armed Forces? If Yes, specify Cuban, Mexi		ican, etc.)	Black, White	e, etc. Cícan
8	ours red',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	эспу:		Specify: Ame	erican
21215-0036	72 h	Be Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during n	most of working	7	6b. Kind of Business/l	ndustry
12	within ne.	mpi	Elementary/Secondary (0-12) College (1-4or 5+) ii/e. DO NOT use retired)			<b>.</b>	
C)	filed v Hygie ther t	ပိ	9 Food Service Worl		First, Middle, Ma	Nursing Ho	ome
and	ontall	Be	Herbert Ford Si	Shirley	Thomas	aiden Sumame)	
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I was seen a 23e or 28e-f ehow imarked other than "naturel", or items 23e or 28e-f ehow umatic event, the Medical Examinatment be notified at	T <sub>o</sub>	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nur			City or Town State 7	in Code)
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "naturel", or Items 23a or 28a-f ehow any injury or other trsumatic event, the Medical Exeminating must be notified at once.		Sharon T. Ford-Yates/Sister 9209 Genoa Avenue			•	
ře,	s 1 a of Hei item othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Dat		oc. Location - City or	
altimore,	Page nent c int: If		1 🖫 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Fort Lincoln	03/31/	2007 B	rentwood,	MD
alti	permit. Departn Imports any inju		21. Signature of Funeral Service, Licensee 22. Name and Address of Fa	acility Jef	ferson	Funeral Ch	ape1
<u>m</u>	8258		Joanna C. Kllberry 5755 Castlewe	ellan Dr	, Alexa	ndria, VA	22315
**			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each are	h as cardiac or r	resurratory arres	it,	Approximate Interval Between
	Pnysician j	) ii	Immediate Cause (Final disease or condition	0111	10110	1	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a c , we juence of):	July -		10)	
re.	Examiner	_	Sequentially list conditions, b	mos	•		
رو	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
7	xecul and al-trar	Examiner	that initiated events c. Due to (or as a consequence of):				
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicalE					
Ö	ificate g phy as the	edic	U.				
Box	leath certific attending pl	M/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli-	very
	deat	Physician/Med	in the past 12 months?  1   Ves   2   No			Month	Day Year
0.	at the by the	hys	9 Unknown				
	res that the de	by 6		Part I.	23e. Did toba	cco use contribute lo	the cause of death?
ord	w require been si should b	ted			1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown
ဝိ	las b	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
Vital Records,	The la cate hay	Co			performe	death?	2 □ No
<u> </u>	Physician: Th r this certificate ral director, pag	Be	Hamilal .	Place of Death (0	Check only one)		
	Phys this ral dir	P.				ce 6 ☐Other (Spec	ıfy)
Division of	Jing Afte fune	ertification:	1 ⊟Natural 5 □ Pending (Month, Day Year) Injury Work?		d. Describe how	injury occurred	
<u>s</u>	Attendi death ctor: A y the fu	fica	3 Suicide 6 Could not be 28e Place of Injury At home farm street factors office		f Location (Street	et and Number or Rui	ral Route Number
É	s after	erti	4 Homicide determined building, etc. (Specify)		City or Town,	State)	arrioute realizer,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	SaiC	29a. Certifier  (Check only  (C	te and place, and	d due to the cau:	se(s) and manner as	stated.
	To the H within 24 To the F complete	edicai	one) and manner stated.	death occurred	at the time, date	and place, and due	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and little of certifier 29c. License number	ber / / _	29d	. Date signed (Month)	Day, Year)
		,	56	14		3127	10/
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Nasreen Kango, M.D. 7701 Carroll Avenue Takoma	Dom! 3	MD 0000	12	
.(80	Sta	e	31. Date filed (Month, Day, Year)	Park, I	MD 2091	LZ '	
	Registra		APR 0 3 2007 Server & locale				

DHMH 17 Rev 1/2001

**ORIGINAL** 

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Пау Physician Month Year Fowlkes 2007 Yvonne /Medical Geneva 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospitell FSCR ltmar e 8. Date of Birth (Month, Day, 07 17 If Under 1 Year Year) 22 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 1 M X F Months Days Hours WV Director 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notified Baltimore 1 X Yes 2 □ No Director MD NΔ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21216 3100 Garrison Blvd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. X□ Never Married 2□ Married Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Nurse 3yrs 12th grade permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lena Owens Matthew Fowlkes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3100 garrison Blvd, Baltimore, Md 21216 Stanton-Sister Idella L. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Coleman Family 4/3/07 Virgilina, VA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Ligensee 21215 23a. Part1. Firer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Saphic Shock **Physician** /Medical Due to (or as a consequence of): moid Colon Carcinoma Examiner inoperable mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of): ¿ attending physician and for use as the bunal-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) detached 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No ertension 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performe rmed? 2☑No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🕏 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 v Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: neral Director: After the filled in by the funeral within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

3 State

Medical

(Check only one)

29b. Signature and title of certifier

NORMA

31. Date filed (Month, Day, Year)

Registrar

inal

29c. License number

DOO 296

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

03

Mark Francis Florian

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		I-For State Registrar		Cer	rtificate c	of Death				Re	g. No.			
Physicia	ın/	1. Decedent's Name (First, Midd		_						Date of Deat Month	Day Year		3. Time of I	
ledical Examir			ark F. F							March 29,	2007		0130 h	ırs
7		4a. Facility Name (if not institution Upper Chesapeake M		umber)		4b. City, To Bel Air	wn, or Lo	ocation of	Death		4c. County o	r Death		
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24Hrs. 8 Min.		th(MM/DD/YYYY)			land
	ŀ	212-70-1693 Usual Residence of Decedent	1 X M 2 F		49 Y	5.			ш	12/20	6/1957			
any	ľ	10a. State 10b. County		10c. City,	Town or Loca	ation							10d. Inside	City Limits
Aaryland 28a-f show i at once,	칟	MD Hari	ford		Edg	gewoo	d						1 Yes	2 <b>X</b> No
e Maryland or 28a-f sho	Director	10e. Street and Number 1836 Johr	n Dr	•		10f. Zip C	ode 21(	140		10	og. Citizen of What		ry?	
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eath v item	Funeral		arried Armed F			Yes, specify					White			
ifter d	by Fi	3 Widowed 4 Div	1 Yes rorced If Yes, Give Ye or Dates:		1	Yes 2	X No	specify:			Specify:	wh	ite	
ours a		15. Decedent's Education (Spe		ade completed)		ent's Usual O					16b. Kind of Bus	iness/In	dustry	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menial Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)		1-4 or 5+)		etail				,	sh	oes		
nore, MD 21215-0036 ges I and 2 should be filed within 72 nt of Health and Mental Hygiene. T: If item 27 is marked other than other traumatic event, the Medical	e Co	17. Father's Name (First, Middle Frank Flo					18	.Mother's	,		Nemec		<u> </u>	
212 uld be Menta marke	<b>m</b>	19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Numb			nber, City or Town	, State,	Zip Code)	
MD ; id 2 shot allth and m 27 is aumatic		Michael Flo	rian/ b	rother	14	Armo	or (	t.	Balt	imore	e, MD 2	122	0	
무무를ㅌ롱		20a. Method of Disposition			Place of Dispo	osition (Name		eterv.	0	)ate 15,	20c. Location -			
MOFE Pages 1 cent of 1-		1XX Burial 2 Cremation 4 Donation 5 Other S			norial		ann c		2007	7	Middle	Ri	ver,	MD
Baltimore, permit Pages I an Department of He Important: If ite	Ì	21. Signature of Funeral Service		FICH	F32	Name and A	ddress o	f Facility	Cha	nel	8800 Parkv			
<b>m</b> 82 5 5		1/1/20-1SK	1/		An	id Cre	emat	ion	Ser	vices	Parkv	1110		
Physician		23a Part I. Enter the disease, or failure. List only one cause	on each line.	caused the death	. Do not enter	the mode of	dying, su	uch as car	rdiac or re	espiratory arre	est, shock, or hea	irt	Between	Onset and
Examiner	Ì	Immediate Cause (Final disease or condition resulting in death)		y artery t		is						-1		eath
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Records, P.O. Box 68760, The law requires that the death certificate be tate has been signed by the attending physicage 2 should be detached for use as the burnage 2.	Ž	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes	, outcome of preg birth	mancy	etal death		Ectopic	pregnanc	y	23d. Date of Month	delivery Da	ay	Year
O. Box 687 at the death certific d by the attending packed for use as the	Physiciar	past 12 months?	4 Preg	nant at time of de	44-	Other (Speci								
BC BC	چُ	Part II. Other significant condi	a Chiki		eculting in the	underlying	ause div	en in Par	+ 1	23e Did to	bacco use contri	bute to th	ne cause of	f death?
, P.O.		Part II. Other significant condi	dons contributing	to death but not i	esulting in the	didellying (	ause giv	ennina			2 No 3			
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Records, The law require ficate has been si	Completed by	·							-	autop perfor	rm <u>ed?</u> d	eath?	empletion o	
<b>止</b> `		25. Was case referred to medical			<u> </u>	20	6.Place c	of Death (	Check onl		2 10 1	<b>✓</b> Yes		140
	o Be	examiner?  1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DO	)A O	ther4	Nursing I	Home 5	Residence 6	Other:		
n of Wirding Physic	-	27. Manner of Death	28a. Dat	e of Injury th, Day,Year)	28b. Time o	f Injury 28		at Work?	1	3d. Describe l	how injury occurre	ed		-
tendi death the fi	atio		iding estigation					es 2						
Division tal or Attendi rs after death al Director: /	Certification:	3 Suicide 6 Cou	ald not be 28e. Pla ermined (Specify	ace of Injury - At h	nome, farm, st	eet, factory,	office bu	ilding, etc	28	or Town, S	Street and Numbe State)	er or Run	al Route N	umber, City
DIVI DIVI To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying P	Physician: To the basis	est of my knowled	dge, death occand/or investig	curred at the	ime, date	e and place death occ	ce, and du	ue to the caus	se(s) and manner and place, and d	as state	d. cause(s)	
To t With To t	Medical	29b. Signature and title of certifi	and manner	stated.			License				29d Date signe			ar)
		Potra - aner	D	OC.L			O.C.M	I.E.			March 29, 2	2007		
1		30. Name and address of person	n who completed ca			=		,	11.2	MD 0101				<u> </u>
Ø	o. k	Patricia Aronica-Polla		tant Medical Registrar's Signat		111 Pe	nn Stre	eet, Bal	ıtımore,	MD 2120	1			
Regist	tate trar	31. Date filed (Month, Day, Year, APR 0 3 2	007	her De	Mess			_						
DHMH 17 Rev 1/2	001		•		ORIGIN	AL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Albert Vernon Franz, Jr. 6:26 P 27. 2007 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1**∑**M 2□ F 79 217-24-2960 14. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 Upton Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XI Yes 2 □ No 1 946 − If Yes, Give Year or Dates: 1949 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation - Driver Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert A. Beulah E. Franz Knopp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Giro (daughter) 2007 Churchill Downs Ct., Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem'l Park 3/30/07 Elkridge. Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licenses Jaco Mille 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cymphana months Due o (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NO PCQ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Physician** /Medical **Examiner** The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, the attending pl

Examine Physician/Medical 2 Be Completed page 2 s Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

show r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23s any injury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

with the Maryland

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

2+1

To the

State Registrar

Medical

27. Manner of Death 1 Natural

3 Suicide 4 Homicide

29b. Signature and title of certifier

29a. Certifier

6 Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

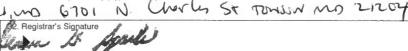
ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) Merch 28 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

- CHAMES, MO 6701 31. Date filed (Month, Day, Year)

APR 0 3 2007



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrer		Maryland / Depa		t of H	ealth a		lental Hyg		07	10427	
	٥.		1. Decedent's Name (First, Middle, Last)					2. Date of Death		Year	3. Time of Death			
	Physicia /Medic Examin		Deborah Ann Fischbeck							April	2,	10:30 A M		
								or Location of Death				4c. County of Death		
			0 0					Perry Hall  f Under 1 Year   If Under 24 Hrs.   8 Date of Birth				Baltimore		
	Funeral Director		219-62-1968	M 2XF	Age (In yrs. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Dec. 15	, 1955	9. Birth	place (State or Foreign intry) Maryland	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Limits	
	nd 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28e-f show r traumatic event, the Madical Examinar must be notified at	ctor	Maryland Baltimore Perry Hall										1 ☐ Yes 2 No	
		Olre	10e. Street and Number 10f. Zip Code							1	_	of What Cou	•	
		eral	9908 Gunforge Road  11 Marital Status 12. Was Decedent Ever in U.S. 13.				21128					U. S. A.		
99		/ Funeral Director	1 Never Married 2 Married	Amed Force:  1 Yes 2 [ If Yes, Give	YINo i	Was Deced If Yes, spec 1 ☐ Yes		spanic Origin, Mexican  Specify:	gin? (Spe , Puerto	ecity Yes or No- Rican, etc.)		Black, White	, etc.	
21215-0036		ed by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:						16h			Specify: White  . Kind of Business/Industry		
15		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)						of worki	ng	TOD. KING	of Business/industry		
213				4 Year	\$	Proce	ss S						Department	
Maryland		Be	17. Father's Name (First, Middle, Last)  Christian W. Fisc	bbook	7 to					(First, Middle, I		тате)		
Ž		ဥ	19a. Informant's Name/Relationship (Typ			na Address	(Street a				· · · · · · · · · · · · · · · · · · ·	wn State 7	in Code)	
			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Sara F. English (Mother)  9908 Gunforge Road, Perry Hall, Maryland 21128											
ore,	es 1 and of Healt I Itam 2 r other		20a. Method of Disposition 1 □ Burial 2 🕱 Cremation 3 □ Re		20b. Place of Dispo				-			ion - City or 1		
Baltimore,	permit. Page Department o Important: If eny injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify)		Bayview (			1					Maryland	
Ball			21. Signature of Funeral Service License							imunek altimor				
	Hospital or Attending Physician: The law requires that the death certificate be 14 hours after death certificate be 14 hours after death certificate has been signed by the attending physicial transfer Director. After this certificate has been signed by the attending physicial tely filled in by the funeral director, page 2 should be detached for use as the burneral director.		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
			Immediate Cause (Final disease or condition resulting in death)	<u> </u>	JAMOUS CA	MOIN	omA	BAS	E 01	FTONGU	8		23 Month	
			Immediate Cause (Final disease or condition resulting in death)  a. Sequentially list conditions  b. OTAL BLEEDING TO CANCER  Disease of Conditions  b. OTAL BLEEDING TO CANCER  2.7								2 24-1			
B		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	TINU TO CANCEL							201193			
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
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687		pa	d.											
Вох		M/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d.	23d. Date of delivery		
O. B		by Physician/M								Month Day Year			Day Year	
<u>α</u>			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?				
rds		leted b	DIAGRETES MELLINS							Yes 2□No 3□Probably 4□Unkno			bably 4 Dunknown	
Vital Records,		plet								24a. Was a	у		opsy findings available ompletion of cause of	
		Comple								perform 1 Yes 2	ned? No	death?	2 No	
ŽĬ.		Be	25. Was case referred to medical available 26. Place of Death (Check only one)											
of		); To	1 Inpatient 2 ENOutpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify)									fy)		
jon		atlor	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No											
É		ertiflcation;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
J		Medical Ce	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within 2 To the comple		29b Signature and title of certifier 29c. License number							2	29d. Date signed (Month, Day, Year)			
•			D28133								4/2/07			
	. 2		30. Name and address of person who con	pleted cause of	death (Item 23a) (Type,	Print) STOS N	CHT	RIE	3 8	- SUME !	wa B	447ME	XUE 111)21201	
•	Sta		31. Date filed (Month, Day, Yéār) 32 Registrar's Signature											
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2007 **Physician** Lea Frankenfield Dorothy March 20 7:59p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 1267 Emerald Ridge Drive Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Days Hours 1 ☐ M 2 ☐ √F 218-42-1249 62 MD Sept 1944 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 10a State 10b. County MD 1 ☐ Yes 2 No Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1267 Emerald Ridge Road 21158 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph L. Walsh Veronica Lonergen ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis Frankenfield (spouse) 1267 Emerald Ridge Dr., Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-3-07 Crownsville, MD Crownsville Vet. Cem. 21. Signature of Funeral Service Licensee

Pougla Cught Auroust 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** garto en teatine 12 2006 /Medical حاد ک Due to (or as a consequence of): Examiner equentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner death certificate be executed burial-transi Due to (or as a consequence of) attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No. 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy Tobacco 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Tyes Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P I hours after death.
-uneral Director: After t After 1 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Box 68760, Division or Vital Records,

State

Registrar

DHMH 17 Rev 1/2001

completely

(Check only one)

29b. Signature and t

31. Date filed (Month, Day, Year)

APR 03

ted cause of death (Item 23a) (Type, Print) Kaier

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** FILLOW PHILIP 2, 2007 2:00 A APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL 1777 OLD WESTMINSTER PIKE FINKSBURG 9. Birthplace (State or Foreign Country) NEW JERSEY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F Months Days Hours 85 2/28/1922 153-16-4903 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√ No FINKSBURG MD CARROLL Directo 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe USA 23a 1777 OLD WESTMINSTER PIKE 21048 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give , or Items be filed within 72 hours after dital Hygiene. die other then "natural", or Item Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE δ IIWW 3 XWidowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) LITHOGRAPHER PRINTING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any njury or other treumstic event 2008 Be FILLOW HUMBLIS PAUL ANNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21048 19a. Informant's Name/Relationship (Type, Print) PAULETTE FERNEKEES -DAUGHTER 1777 OLD WESTMINSTER PIKE, FINKSBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ALL COUNTY CREMATION 4/2/07 SYKESVILLE, MD 5 Other (Specify) Suneral Sarvice Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. ignati 254 E. MAIN ST., WESTMINSTER, MD 21157 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, an failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca se (Final disease or co dition resulting in death) Physician /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the attending physician and hed for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav signed by the atte in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 25 No st or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Director: After the 28b. Time of 28c 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a To the Funerel I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title WV cause of death (Item 23a) (Type, Print) 30. Name and address of p mplete ONER RE 121 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 03 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30<sup>Day</sup> **Physician** Month 2007 3:30 ам Lee Gause Frances /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto Towson Stella Maris If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sev 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 T F Yrs Director 261-06-4651 56 S.C. 2-7-1951 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shoved is a show the standard is a show the standard in the standard is shown in the standard is shown in the standard in the 1 X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 3209 Windsor Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 30,200 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Thouschart: If Item 27 Is marked other than "natuu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland Specility 12th grade Opeartor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearly Gause Gracie Grate 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Thurman-Daughter 1807 Cobourg Ct Balto, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Mem Park 4-5-2007 Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 21202 ady 1101 E. North Avenue MDBalto, and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) W **Physician** /Medical Due to (or as Transequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 ☐ Unknown ģ has been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate perform 2 No 1□ Yes 1 ☐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA HOZDICA 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 DNatural 2 Accident 5 Pending Injury thin 24 hours arter con-1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pood 32. Registrar's State

DHMH 17 Rev 1/2001

Registrar

2

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r **Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

show

Maryland 21215-0036

Baltimore,

Pages 1

r 28a-f show notified at

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Funeral

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Hospital or Attending

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completely

Medical

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Examine Physician/Medical Completed Be ို Certification: filled in t

END

27. Manner of Death

2 Accident

3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SHULTZ

25. Was case referred to medical examiner?

1 Yes 2 No

PLEURAL EFFUSIONS

STAGE

5 Pending investigation

6 Could not be

determined

PERICARDIAL TAMPONADE

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001

RENAL DISEASE

m. D.

32. Registrar's Signature

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES OOI

1 Yes 2 No

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

(Month, Day Year)

28a. Date of Injury

20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensed 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 13 DAYS SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ finknown

24a. Was an

1∐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARCH

BALTIMORE MARYLAND

29d. Date signed (Month, Day, Year)

31

2007

25555

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Registrar

SOUTH HANGUER STREET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #17 Per FH G866 4/03/07 e Historicate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Thomas Gregg 11:57 PM 03 29 /Medical 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UnPhersity of Maryland Medical Conter BaitPmore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 □ F 213-30-5337 Director 74 Dec.10,1932 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A1⊈Yes 2□No Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 5533 Nome Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: Korea altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: Black 3 Widowed 4 Divorced Completed of Health and Mental Hygiene. Item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine shop <u>10th grade</u> Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Acy GF Gregg ၉ Anna E. Wells 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Audrey Louise Simmons/Daughter 1311 Gold Meadow Waypt. 204 Edgewood, Md21040 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4/6/07 Jo Department of Important: If It any Injury or conce. 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Owings Mills, Md 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licens 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-ST elevation myorandral in arction /Medical Due to (or as a consequence of): Examiner 2 days Sequentially list conditions, any leading to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending physic IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy certificate performe 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **√**No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturai Iniury death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ္ 17400

State Registrar 22 S. Greene Sto Balt Smore, MS 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

José C. Cabassa

31. Date filed (Month, Day, Year) APR 0 3 2007 MB

32. Registrar's Şignature

			For State Registrar	•		d / Depa		t of H	ealth a	and Mental		Bon	7 10	433
			Decedent's Name (First, Middle	a, Last)						2. Date of	of Death	-	3. Tim	e of Death
	Physicia /Medic		Kelli Ann Gille	<b>y</b>							1 29,		7:00	) A <sup>M</sup>
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		,		Location o	f Death		County of		
			315 Sunray Ct		1		Abi:	ngdoi	n If Under 2	A Hrs. O Days		Harfo		ata ar Faraiga
	Funeral Director		5. Social Security Number 214-98-3842	6. Sex 1 ☐ M 2 K F	7. Age (In yrs. 29	Yrs.	Months		Hours	Min. (Month	h, Day, Year	)	Country) Maryland	
	Du A	1	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Insid	e City Limits
	fsho	ō	Maryland Harfo	ard	Λb	ingdon							1.0	Yes 20 No
	28e	Director	10e. Street and Number	JI u	AU	inguon	10f. Zip					itizen of Wh	at Country?	
	death with the Maryland ms 23a or 28e-f show		315 Sunray Ct					210	09		U.S	.A.		
9	within 72 hours after death with the Marylan ene. Then "netural", or itams 23a or 28e-f show the Maxical Examiner must be putilised at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Marria 3 □ Widowed 4 □ Divorced	Armed F	2 X No live	1	Was Deced If Yes, special 1 ☐ Yes		ispanic Origin, Mexican Specify:	gin? (Specify Yes ( , Puerto Rican, etc	or No- c.)	Black,	American India White, etc. White	n,
213-0030	2 hou	led	15. Deceden	t's Education		16a. Dece	dent's Usua	al Occupa	ation	t of working	16b. l	Kind of Busi	ness/Industry	
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7	be filed withing tal Hygiene. d other then evant, Ire M	Con		8		Busi	ness .	Anal					Price	
yland	be tile tal Hy doth evant	Be	17. Father's Name (First, Middle,							erly A. I		n Sumame)		
2	2 should be filed v n and Mental Hygie is marked other t raumatic evant. ID	۴	Joseph C. Gille  19a. Informant's Name/Relations			10h Maili	na Addross	(Stroot		er or Rural Route N		or Town St	late. Zin Code)	-
Ma	ges 1 and 2 should it of Health and Men if itam 27 is marke or othar traumatic		Scott Gilley (							ngdon, M			are, zip oode,	
as a	othar tr		20a. Method of Disposition		20b. F	Place of Disponentery, creating	osition (Nai	ne of	20)	Date	20c. l	_ocation - C	ity or Town, Star	e
ē E	Pages ent of nt: if i		1 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		n State	rkwood			1 _	4/02/200	7 Bal	timor	e, Mary	land
baltimore,	permit, Pages I Department of I- Important: if ita any injury or ot 20058.		21. Signature of Funeral Service			2:	2. Name ar	nd Addres	ss of Facilit	y Schimuno Shail RD.				Bel Air
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat							il, m	Approx	imate Between
	Physician		Immediate Cause (Final										Onset	and Death
	Physician /Medical		disease or condition resulting in death)		eta stat		31 (	mc	~				5 12	412
	Examiner		Control of the Control of the contro	,										
7	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a consec	quence of):								
Υ.	te be executed ysician and ne burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a consec	mence of):								
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280	phys phys s the			d										
XOR	death certificate e attending phy od for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		¬					23d. Date	of delivery	
ň	0 0 0	icial	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pre	birth 2 Feta gnant at time of c		⊒Ectopic p ⊒ Other <i>(s)</i>		/ 		_	Mont	h Day	Year
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Š,	de ed	by P	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the t	underlying (	ause giv	en in Part I	. 23ө.			oute to the cause	
g	w require been sig should b	ted									1 Yes	ZUMPNO 3	Probably	+ DOUVIONII
ပို	The law requires ate has been sign bage 2 should be	Completed								24a.	Was an autopsy performed?	pri	ere autopsy find ior to completion ath?	ings available of cause of
r =		Co								10	Yes 22		Yes 2 1	
Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hoenital:		1.500		Oth	oc.	of Death (Check		0 TO:	(0	
ō	Phys rthis ral dii	1: To	1 Yes 2 No	28a. Dat	☐Inpatient 2☐ e of Injury	28b. Time of		28c. Injur	y at	ursing Home 5 👗 28d. Des	cribe how inj			
0	th. th. Afte tune	tion	1 ☑Natural 5 ☐ Pendi	ng (Mo igation	onth, Day Year)	Injury	М	Wor 1 □	rk? ∣Yes 2. 🗌	No				
DIVISION OF	or Attanding P after death, I Director; After t d in by the funera	ifica	3 Suicide 6 Could 4 Homicide determ	ningd 200. Fld	ce of Injury - At h	iome, farm, st	reet, factor	y, office			tion (Street a		r or Rural Route	Number,
ā	tal or s afte al Dir	Certification:	4   Aofficide	Bui	idilig, etc. (Speci	·y/				,				
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifyi (Check only 2 Medical one)	ng Physicien: To t Examiner: On the and ma	he best of my kn basis of examina anner stated.	owledge, dea ation and/or i	th occurred nvestigation	at the tir n, in my o	me, date ar opinion, dea	nd place, and due t ath occurred at the	to the cause time, date a	(s) and man nd place, ar	ner as stated. nd due to the ca	use(s)
	Fo the within Fo the Somple	<b>B</b> e	29b. Signature and title of certific	ər			29	c. Licens	e number		29d. D	ate signed	(Month, Day, Ye	ar)
			1 moth	~ MO			ì	040	820		Ma	nch 3	30,200	7-
	12		30. Name and address of person		use of death (Ite	m 23a) (Type	, Print)	_		-		A	, 27	
	10		YVONNE OTTAL	MANO MI	9103	Fran	nklin	Squa	ne D	r Back	mre	AM 12 ;	21225	
	Sta		31. Date filed (Month, Day, Year		Trogistial 5 Oign	atero								
Dire	Regist	100	APR 03	2007	Merch S	· An	W.							
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month **Physician** Catherine Mary Gwiazdowski March 2007 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 832 Seneca Park Road Baltimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🙀 F Days Hours Min. 216-52-2160 78 Director Maruland May 30. 1928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 🕱 No Maruland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 832 Seneca Park Road 21220 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify. þ White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker s 1 and 2 should be filed wi Health and Mental Hygien tem 27 Is marked other th Own Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Lordi 0 Mary Urnisi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 bepartment of Health ar Important: If item 27 Is any Injury or other trau Patricia Ford (daughter) 2416 Parliament Drive, Abingdon, MD 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 3/31/2007 | Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signatore of Funeral Service Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): Schoolis were disease or condition resulting in death) /Medical Examiner pinton Sequentially list conditions Physician/Medical Examiner rany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Hunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 100 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day 5 Pending investigation 1 🗌 Yes 2 No 2 Accident

P.O. Division or Vital Records, Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica filled in by within 24 hours at To the Funeral D

9

DHMH 17 Rev 1/200

State Registrar

31. Date filed (Month, Day, Year, 3 APR 0

29b. Signature and title of certifier

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

at 25 tch 32 Registrar's Signature

Johns

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1710021

29c. License number

003829

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

07

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Emerson Russell Garrison, Jr. Q007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital ER Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 219-32-5170 71 2-4-1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1√Xes 2 No N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3939 Roland Avenue Apt. 823 21211 IISA Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes ※※ No If Yes, Give Year or Dates: 1 Never Married XXMarried 1 ☐ Yes 2€XNo Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Floral Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emerson R. Garrison, Sr. Irma Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3939 Roland Avenue Apt. 823Maryland 19a. Informant's Name/Relationship (Type. Print) 3939 Roland Avenue Susan P. Garrison wife 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition **X**Burial 2 ☐ Cremation 3 ☐Removal from State Druid Ridge Cemetery 4/2/07 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, In 3631 Falls Road Baltimore, MD 21211 Funeral Service L Part1. Inter the disease shock, or heart failure. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) diac MINS Due to (or as a consequence of) OCOLO110 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

-28a-f

Items 23a or

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Midical Examiner once.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra attending physician for use as the buria this After this I Director: d in by the

Physician/Medical

by

Completed

Certification:

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2 Medical

Division or Vital Records, P.O. Box 68760,

			· · · · · · · · · · · · · · · · · · ·	1) Yes 2[	□ No 3 □ Probably 4 □ Unknown
				24a. Was an autopsy performed? 1∐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
5. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	S □Other (Specify)
7. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif		ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	slcian: To the best of my kno iner: On the basis of examina and manner stated.				and manner as stated. place, and due to the cause(s)

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within 24 hours aft

To the Funeral Di

completely filled in

State Registrar . Name and address of p rson who completed cause of death (Item 23a) (Type, Print)

License numbe

William

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

APR 03



**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Bradley $\mathbf{P}^{\mathsf{M}}$ James March 30, 2007 Geaslen 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1601 Gray Haven Court Dundalk Baltimore 8. Date of Birth (Month, Day, Year) November 7, 1949 if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 M 2 □ F 57 Maryland Director 214-56-5777 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21222 items 23a 1601 Gray Haven Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No if Yes, Give 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural", ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker General Motors 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Bradley Geaslen Catherine Louella Newberger ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 1601 Gray Haven Court, Dundalk, Maryland 21222 Carol Lynn Geaslen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April Tate 5 permit. Pages 1 Department of IImportant: If Ite any Injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 5 ☐ Other (Specify) Baltimore Md. 4 ☐ Donation 2007 21. Signature of Funeral Service License Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease of complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? s certificate has lirector, page 2 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🗌 Inpatient မ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 To the Hospital

Medical Certification: within 24 hours after death

To the Funeral Director:,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar **ORIGINAL** 

1. Decedent's Name (First, Middle, Last) Physician Medical ROSE ANNE GILBERT				
BUSE ANNE GILLBERT		2. Date of Death Month	Oay Year	3. Time of Death
A C W. Al. M. A. W. A. M. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A. M. A	n, or Location of Death	MARCH	30, 2007 4c. County of Death	3:10 A.M
Examine			BALTIMO	RE
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye		8. Date of Birth	0 Right	place (State or Foreign
Director 214−30−3902 1□ M 2X□ F 94 Yrs. Months Day	ys Hours Will.	(Month, Day, 1 8/23/19	12 IR	ELAND
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
BALTIMORE TIMONIUM				1 ☐ Yes 27€ No
MD BALTIMORE TIMONIUM  106. Street and Number  107. Zip Code	e	10	g. Citizen of What Cour	ntry?
10a. State 10b. County 10c. City, Town or Location  MD BALTIMORE TIMONIUM  10a. State 10b. County 10c. City, Town or Location  TIMONIUM  10b. Street and Number 10f. Zip Code  13 MULLINGAR COURT UNIT 102 2  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent County 13. Was Decedent County 15 and	1093		USA	
1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	of Hispanic Origin? (Stuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify: WI	
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  STH GRADE  15. Decedent's Usual Oct (Give kind of work do life. DO NOT use ref HOMEMAKER	cupation ne during most of wor	king	6b. Kind of Business/In	dustry
College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  HOMEMAKER	ne during most of wor tired)		OWN HOME	
Elementary/Secondary (0-12)  STH GRADE  17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Ma		
Tr. Father's Name (First, Middle, Last)  PATRICK FINN  PATRICK FINN		LE SCULLY		
PATRICK FINN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street	eet and Number or Ru	ral Route Number,	City or Town, State, Zip	Code)
HARRIET FOWLER/DAUGHTER 13 MULLINGAR			TIMONIUM, N	
20a. Method of Disposition  20a. Method of Disposition  XX Burial 2 Cremation 3 Removal Irom State  4 Donation 5 Other (Specify)  21. Signature of Euperal Service Licensee  22. Name and Ad  8521 LOCH			Oc. Location - City or To	
XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Euneral Service Licensee 22. Name and Ad	1		YKESVILLE, FUNERAL HO	
21. Signature of European Service Licensee 8521 LOCH	H RAVEN BL		ON, MD 2128	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of cause on each line.	dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical /Medical				weeks
Examiner				
if any, leading to immediate Due to (or as a consequence of):				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Partil.	23e. Did toba	acco use contribute to ti s 2∕3 No 3 ☐ Prob	ne cause of death?
House Cerebovascular Acci	tri M	24a. Was an		ppsy lindings available
The law require the base of the law required to the law required t		autopsy perform	prior to co ed? death?	mpletion of cause of
S S S S S S S S S S S S S S S S S S S	26. Place of Dea	1 ☐ Yes 2 f ath (Check only one,	·	212 No
examiner?    Solution   Property    Other: 4 Nursing H	lome 5 ☐ Residen	nce 6 Other (Specif	ý)	
O & E TO STAND THE PROPERTY OF THE PROPERTY O	njury at Work?	28d. Describe how	w injury occurred	
27. Manner of Death    Second    Yes 2 No	28I. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,	
The late of the la	a time, data and place	and due to the cou	uso(s) and mapper as s	tatod
29a. Certifier 1 Check only one) 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 39a.				
29b. Signature and title of certifier	ense number	290	d. Date signed (Month,	Day, Year)
= Presting Wright (110) D	5274	FO I	March S	5007
30. Name and address of person who completed cause of death (flem 23a) (Type, Print)  ERNESTINE WRIGHT, M.D. 2300 DULANEY VALI	LEY ROAD	TIM	ONIUM MD	21093

DHMH 17 Rev 1/2001

GILBERT, ROSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Frank D. Hardester, Sr. 27,2007 march /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner VA maryland Heal Hoare System

5. Social Security Number 6. Sex 7. Age (In yis. last birthday Birthplace (State or Foreign Country) Nome Known to Physician; Hardester, Frank D. Hardester, Frank D. Baltimore, Maryland 21215-0036 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 1 M M 2 □ F Director 212-28-7681 June 1, 1931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location show Medical Examiner must be notified at 1 ☐Yes 2 ☐No Director Halethorpe 110f. Zip Code MD Baltimore 28a-f 10g. Citizen of What Country? 10e Street and Number Items 23a or 2617 Braun Avenue Funeral 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1950-14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 'natural", or f Yes, Give rear or Dates 1 ☐ Yes 2☐ No Specify Specify: white þ 3 □Widowed 4 □ Divorced 1952 Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and 2 should be filed within salth and Mental Hygiene. n 27 is marked other than College (1-4or 5+) the Meat Cutter Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hardester, Sr. Elvira Conklin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once. 2617 Braun Avenue Baltimore MD 21227 Gail Hardester/Daughter-in-I 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04-02-2007 | Elkridge Md 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227
Approximate Interval Between Onset and Death 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Vizheimer's Unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 6876රිථ Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? /es 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural Natural 5 Pending investigation within 24 hours area com.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/ YAMaryland Meadth Care System, Perry Point, MD 21902 31. Date filed (Month, Day, Year) APR 0 3 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8866 4-10-07 vt. State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Theresa Ann Heavener aka 2. Date of Death 3. Time of Death March 30, 2007 **Physician** Theresa G. Heavener <del>Theresa Ann Heveaner</del> 6:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M **XX**F 81 Yrs. 220-18-7575 Director Oct. 9, 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits Examiner must be notified at 1 □Yes ŽXNo Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 11715 Terry Town Drive items 23a 21136 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify: White 3XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene 6th Homemaker Own Home 27 Is marked other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Adoloh Grabowski Alexandria (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Barbara D. Heavener (Daughter) 11715 Terry Town Drive; Reisterstown, Maryland 21136 20b. Place of Disposition (Name of Lorraine Park 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages
Department of Important: If it any Injury or o XXBurial 2 10 remation 3 Demoval from State 4 Donation 5 Other (Specify) Cemetery Woodlawn, Maryland 21. Squature of Fure and ervice Uses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road; Owings Mills, MD 21117 . Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immade te Cause (Final disease or condition resulting in death) Physician e to (or as a consequence of) Comcer montas /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as the attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No cate has been si page 2 should Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Atter t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident nin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only within To th 29c. License number 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

D

6201

32. Registrar's Signature

harles ST Towson mo 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Regina 1, April Hagert 2007 1:35 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1600 Rita Road Baltimore Dundalk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 X F 71 218-30-7191 Director November 26,1935 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 TYes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Rita Road 21222 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2[**X**No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 2 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Consumer Credit Elementary/Secondary (0-12) College (1-4or 5+) 12 years Counseling Receptonist 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Be Henry C. Diehl Sr. t and 2 should be Health and Ment Margaret Buchta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum Debra Re Daughter 1600 Rita Road, Dundalk, Maryland 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apriliate 5. Pages 1 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Memorial Baltimore, Maryland 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD 21222 Mili 23a. P. rt1. Enter the disease, or our plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. c., or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONARY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit L<sup>®</sup> Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 No 3 Probably 4 Unknown , page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performe 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO Di6619 arasaara n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. VERGARA - SO ARES 9940 FRANKLIN SQUARE DR. BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 3 2007

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Month **Physician** March 30, Margaret Mary Haslup 1:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Stella Maris Baltimore Timonium 5. Social Security Number 6. Sex 8. Date of Birth May 25, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🔀 F 359-24-7977 Illinois Director Usual Residence of Decedent 10c. City, Town or Location death with the Marylan 10d. Inside City Limits 23a or 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examlner must be notified at MD 1 ☐ Yes 21 No Director Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Ave., Apt 808 21 221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite mortant: If item 27 is marked other than "natural", or item projuing or other traumatic event, the Medical Examine oney. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Baltimore, Maryland 21215-003 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proof Reader Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be ပ William McInrue Marv Alice Casey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marellen Mayers-daughter 25 Chestnut Hill Rd., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National 4/2/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final CANCER WITH METASTASIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Socuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be execute Division or Vital Records, P.O. Box 68760. Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

2300 QUIANCYVAILEY RD. MAHMOOD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Timortium

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Bernice 4:19 PM Jones 2007 March /Medical 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month Day, Year) 6-10-1939 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2√2 F PA Director 197-32-2947 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits is marked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4800 Yellowwood Avenue T14 21209 Apt USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 ☐ Widowed 4 X Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry N/A N/A al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any liviny or other traumatic event once. Be Roy Hamilton Vernitia Sheed ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Apt L 09

Apt L 09

Balto, MD 21209 19a. Informant's Name/Relationship (Type. Print) Gregory E. Jones -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Greenmount Cem 4-3-2007 Balto, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility  $March\ F/H\ East$ 21. Signature of Funeral Service Licensee Balto, 21202 la Wan 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stroke **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Liceate or in Jun) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) a∏lJnknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hupertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown director, page 2 should Completed been Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate I Type II diabetes mellitus or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospita! 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

completely

within 7

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kimberly Pargeon

03

DHMH 17 Rev 1/2001

29c. License number Employee

16 S. Eutaw St. 3rd floor or 22 S. Greenest.

Number

29d. Date signed (Month, Day, Year)

March 29 2007

Baltimore, MD

21201

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UMM5

Resident Physician

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. OI. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 March 27, 2:15 РМ Richard G. Jones 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days 110 M 2□F Months Hours 45 226-15-4165 Jan.28,1962 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits 1 X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 700 Bever Brook Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Store Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Lee Jones Corrine Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Bever Brook Road, Baltimore, MD Jeanette Holley/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place, First Rock Baptist Church 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 XRemoval from State Prince Edward 4 ☐ Donation 5 ☐ Other (Specify) 3-31-07 County, Bland-Rei 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Tuneral PO Box 325, Farmville, VA 23901 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 106/astumA Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

physician pe

certificate

this

After t

Within 24 hours after occur.

To the Funeral Director: Aft

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

ms 23a or 'must be n

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu

alth and Mental Hv

Baltimore, Maryland 21215-0036

P.O. Box 68760, 2

Division or Vital Records,

Physician:

Hospital or Attending I 24 hours after death.

Director

Funeral

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Completed

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burial-tran the as use ed by the a signed t page 2

Examine Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown þ Completed 25. Was case referred to medical Be 1 Yes 2√2 No ٩ 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 6 Could not b 3 Suicide 4 Homicide 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No

_				20.	Place of Dea	aun (Cni	eck only one)		_		
Н	ospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3	□ DOA	Other: 4	□ Nursing H	lome	5 Residence	6 Other (Specify)	nospice		
1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 □ Yes	2 □ No	28d. I	Describe how inju	ury occurred			
е	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, f	factory, or	ffice		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ıys	ician: To the best of my kno	owledge, death occ	curred at t	he time, d	ate and place	e, and c	due to the cause(	s) and manner as sta	ated.		

29b. Signatur it# of certifier

reurles St Towson mo

29d. Date signed (Month, Day, Year)

APR 0 3 2 31. Date filed (Month, Day, State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAA GN J. CHAWES WY 6701 N. CH N. ( 32. Registrar's Signature

Lionel Johnson State of Maryland / Department of Health and Mental Hygiene 2007 10666 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ March 31, 2007 Lionel H. Johnson 0525 hrs dical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sinai Hospital Baltimore City 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Days Jan. 15,193 Foreign ryland Hours Director 217-30-2585 Months 73 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Baltimore N/A 1x Yes 2 No Maryland 28a-f shov or items 23a or 28a-f show must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 這 2590 Druid Park Drive Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No No 1 959 Yes, Give Year 1 959 Black 1 Yes 2 No specify: Specify: Divorced If Yes, Examiner Ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hoent of Health and Mental Hygiene. Sign Company the Medical marked other than Painter 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Johnson Alvina Holley Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) item 27 is m r traumatic 111 Eagles Lane Maurice Johnson/ Sinking Spring, Pa 19608 6/07 Cem. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, permit Pages I:
Department of H
Important: If it
injury or other crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Owings Mills, Md Garrison Forest Vet. 4 Donation 5 Other Specify 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Lice 5240 Reisterstown Rd Baltimore, Md Approximate Interval 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ailure, List only one cause on each line. Madica Death Cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit Physician/Medical physician the burial -X UNPENDED AMSNPSD, PII, 27, 28a-f, perME, g866, 4/9/07 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o δ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive cardiovascular disease Completed Records, 24b. Were autopsy findings available page 2 should 24a. Was an autopsy prior to completion of cause of has death? performed? Yes 2 No Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Vital Be examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 Other Nursing Home 5 Residence 6 Other this 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred ð After 28a. Date of Injury (Month, Day Year 28b. Time of Injury 27. Manner of Death Certification: Natural Division 1 Yes 2 X No Pending Director: 3/31/2007 unk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide or Town. State within 24 hours a To the Funeral I determined (Specify) hame 2590 Druid Park Lake Dr. Baltimore MD Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b/ Signature and title of certifier March 31, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Travas

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

**ORIGINAL** 

		1	For State Registrar				nd / Depa		t of H	ealth a	and Me	ental Hy	giene Reg. No.	007	P.C. cale	0445
	Physicia /Medic Examin	n , al	4a. Facility Name (If	D. Jon	<b>es</b> ve street and num	nber)				Location o		2 Date of Dea Month April	01,	Yea 2007 County of De Balti	er eath	7:10 A. M
2.8	uneral rector		5. Social Security Nu 482–34–5	imber 6. 5397		7. Age (In yrs <b>72</b>	. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	Date of Birt (Month, Da	y, Year)	9. E		(State or Foreign
Maryland	a-f show		Usual Residence of 10a. State Iaryland	10b. County  Baltim	ore		ity, Town or Lo								1	Inside City Limits 1 ☐ Yes 2 🙀 No
h with th	23a or 28 at be no	Funeral Director	10e. Street and Num 4119 Ra	nber al <b>eigh</b> R	oad			10f. Zip	Code 21208	3		Un	_	en of What	-	America
<b>-0036</b> hours after death with the Maryland	골	þ	11. Marital Status 1 □ Never Marrie 3 □ Widowed	_	12. Was Dece Armed Fo 1  Yes If Yes, Giv Year or Da	rces? 2 X No e X		Was Deced f Yes, spe 1  Yes	_	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		4. Race - Al Black, W Specify: Wh	hite, etc.	ndian,
1215- within 72 ene.		Completed	(Speci	15. Decedent's E fy onfy highest g ndary (0-12)		-4or 5+)	life.	dent's Usua kind of wo DO NOT us ram	rk done d se retired	luring most  )	of working		U.S. Government Social Security Adm			it
عَ اللَّهُ عَلَيْهُ	aven aven	To Be	17. Father's Name (a	. Jones								First, Middle, Whit		Sumame)		
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Baltimore, permit. Pages 1 a Department of Hea	important: any injury o			5 Other (Spec	ity)	DI	uid Rid	. Name ar	nd Addres	s of Facility	Lorin	g Byer	s Fu	neral	Dire	ryland ectors,Ind 1d_21133
Me Exaculed	ysicie	Ical Examir	Immediate Cause (i disease or condition resulting in death)  Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	inal inditions, mediate tying njury	Due to ( b		quence of):	IC.	ES	o Pr	+AG	FAL	CAH	NCETO	- On-	eval Between set and Death months
	ned by the attending phy detached for use as th		IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	months?		nth 2 ☐ Feta antattime of	aideath 3∐	Ectopic pr					2	3d. Date of o	delivery Day	Year
'ds, P			Part II. Other signifi	cant conditions	contributing to de	ath but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did to				use of death?
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Division of Vita	his cer	0	examiner?  1 Yes 2 X 1  27. Manner of eath 1 Natural 2 Accident	No	28a. Date o (Monti		ER/Outpatien 28b. Time of Injury		8c. Injury Work	or: 4 □ Nur	rsing Home	Check only one of the control of the	lence 6	Other (S)	pecify)	
Division Attants after deat	al Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not a determined	28e. Place	of Injury - At h g, etc. (Speci	nome, farm, str ify)	eet, factory	r, office		28	f. Location (S City or Tow	Street and m, State)	Number or	Rural Roi	ute Number,
Diy To the Hospitei or within 24 hours afte	ha Funer pletely filli	edical	29a. Certifier (Check only one)	Certifying P	hysician: To the miner: On the ba and mann	sis of examina	owledge, death ation and/or inv	occurred	at the tim , in my op	e, date and pinion, deatl	d place, and h occurred	d due to the o	cause(s) a date and	and manner place, and d	as stated ue to the	l. cause(s)
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	Stat Registra	Ÿ	31. Date filed (Montl		07 R	egistrar's Sign	ature	de								

enry Kellerma		1- For State Registrar	tate of Marylan		ment of <i>icate of</i>		nd Menta		Reg. No.	200	7 1044
Physici Medical Exam		1. Decedent's Name (First, Mide					_	Date of De Month	Day	Year	3. Time of Death
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		Mercy Hospital				Baltimore					
Funeral Director		5. Social Security Number 095-30-7202		Age (In yrs. last I	birthday)	If Under 1 Ye Months Da		4Hrs. 8. Date of B Min.	irth(MM/DD/	Forei	rthplace (State or
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any		10a. State 10b. County		10c. City, Tox	wn or Locati	on					10d. Inside City Limits
Maryland 28a-f show	ē	VA Henr	ico	Glen	Allen						1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	intry?
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leath v r items	Funeral	1 Never Married 2 X			If Ye	s Decedent of Hi es, specify Cuba	spanic Origin? n, Mexican, Pu	( Specify Yes or No erto Rican, etc.)	0- 14.	White, etc.	rican Indian, Black,
after or	by F	3 Widowed 4 Di	vorced If Yes, Give Year	ea	1	Yes 2 X No	specify:		Spe	ecify: Whi	ite
hours afte "natural", Examiner	ted	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>			a. Decedent during mo	's Usual Occupa est of working life	ition (Give kind e. DO NOT use	of work done retired)		of Business/	•
5-0036 led within 72 Hygiene. other than '	Completed	Elomentary/decondary (0-12)	2 Conlege (1-4		enior	Vice Pr	eciden	+		urity Baltim	
5-003 iled withi Hygiene. I other th	Cor	17. Father's Name (First, Middle	, Last)		-11201	<u> </u>		ame (First, Middle,	Maiden Suri	name)	lore
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Henry Kellerm  19a. Informant's Name/Relations						Donish			
e, MD 21215-0036  1 and 2 should be filed within 72  Health and Mental Hygiene.  "item 27 is marked other than " riraumatic event, the Medical I	To	Linda B. Kell						or Rural Route Nui Glen Alle			
e, N I and Health Fitem		20a. Method of Disposition		20b. Plac	e of Disposit	tion (Name of ce		Date Date	20c. Loca	23039 ation - City or	Town, State
More Pages 1 ient of Fi		1 K Burial 2 Cremation 4 Donation 5 Other S			atory or oth Jernon	erplace) Bapt C	h Cem	3/31/07	G1.	en A11	en, VA
Baltimore, permit. Pages I ar Department of Hes Important: If ite		21. Signature of Funeral Service	Licensee		<sup>22</sup> Ne	ame and Addres	s of Facility uneral	Home	01.	211 1111	CII, VA
Physician	_	23a. Part   Enter the disease, or	complications that cause	ed the death. Do	32	15 Cuts	haw Ave	enue Rich	mond,	VA 2	3230
/Medical	8 20	failuge. List only one cause	on each line.				, suci i as caldie	ac or respiratory arr	est, shock, t	or neart	Approximate Interval Between Onset and Death
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d d ansit		events resulting in death) Last	Due to (or as a cold.	nsequence of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burnal - transit	Medical	UNPENDED	AMENDED								·
760, icate by physic the bur		IF FEMALE: 23b. Was decedent pregnant in ti	20	come of pregnanc	у				23d. Da	ate of delivery	<u></u>
Box 687; death certific	cian	past 12 months?	I Live birth	at time of death	- =	al death 3 er (Specify)	Ectopic pre	gnancy	Mor	nth D	Day Year
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tal Rection: The certificate ector, page	e Co	25. Was case referred to medica	1 ,1			26.Place	of Death (Che		2 🗸 No	1 Ye	es 2 No
Vita hysicia this ce	9 9	examiner?  1 Yes 2 No	Hospital: 1 Inpa	itient 2 🗸 ER/	Outpatient		Other:		Residence	6 Other	n
Division of Vital Records, tal or Attending Physician: The law requires after death al Director: After this certificate has been seled in by the funeral director, page 2 should!	ä	27. Manner of Death  1 ✓ Natural 5 □ Death	28a. Date of ! (Month, Da	njury 28t y,Year)	. Time of Inj		ry at Work?	28d. Describe	now injury o	ccurred	
Siol Attendrated death ector: by the	cati	2 Accident Inve	stigation	Injury - At home,	form street		Yes 2 No	206 Leasting (4	Disease and Mi		Davida Musebas Other
Divis pital or At ours after d ours after d filled in by	Certification:		d not be mined (Specify)	injury ranome,	iaini, stroct	, raciory, office t	Juliuling, etc.	or Town, S		umber or Ru	ral Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	_ !	29a. Certifier (Check only 1 Certifying P	hysician: To the best of								
To the Hos within 24 h To the Fun	Medica		miner: On the basis of each manner state	xamination and/o	r investigatio			ed at the time, date			
	2	29b. Signature and title of certifie	W. 11			29c. Licens O.C.				signed <i>(Mor</i> 28, 2007	nth, Day, Year)
		30 Name and address of person	Mull, MI) who completed cause of	f death (Item 23a	)				, warding		
10		Pamela E. Southall, N	ID Assistant Me	·	,	Penn Stree	t, Baltimore	, MD 21201			
	ate	31. Date filed (Month, Day, Year)	2007 32 Regist	trar's Signature	Anas	ls.					
Regist	nen	711 11 00	EUU! JEEFE	14 July "	1			<del></del>			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 30, <u>Elizabeth Ann Kreft</u> MARCH 2007 08:20FM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Baltimore Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Feb. 15,1930 | Marry land 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 77 Director 218-28-2783 Usual Residence of Decedent 10a, State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2803 Armacost Ave. 21048 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u> Housewife</u> <u>Homemaker</u> alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å ပ Urban C. Hartlaub Theresa E. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Kreft, Jr. -1450 Constance Dr. Westminster, son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, Evergreen Mem. Gardens April 4,2007 Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee Sail Ellis 11605 Reisterstown Rd. Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ADRIIC STENOSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown ģ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ASCENDING AORTIC ANEURYSM 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page certificate perform 2 NO Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending Iniury n 24 hours after death.

ne Funeral Director: A

oletely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7671 OSLER DRIVE TOWSON, MARYLAND 21274 IS KHOO M. State APR 03 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 7:12 PM Herrill Kellum March 2007 /Medical 37 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins

5. Social Security Number Bayview Medical Ctr Baltimore If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F Days Hours Director 212-58-2486 2/12/1949 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County r 28a-f show notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be r 'natural', or items 23a dical Examiner must t 1116 Hewitt Way Funeral 21205 United Stat

14. Race - American I

Black, White, etc. States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No **a** Specify. 3 ☐ Widowed 4 ☑ Divorced Specify. White Completed h and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Research Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merrill W. Kellum ပ Dolores M. Lamparski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Item 27 is or other train Mona Kellum-Bloecher - Sister 929 Green-Mor Avenue Salisbury, Maryland 21804 20b. Place of Disposition (Name of cametery, crematory or other place)
HOLY ROSATY
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ò Department of Important: If any Injury or ortice. 03/31/2007 Baltimore, Maryland 22. Name and Address of Facility David J. Weber 401 S. Chester Weber Funeral Homes P.A. nester Street Baltimore, Maryland 21231 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse wence of): Physician Failure han /Medical Examiner neumonia Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bivision or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) adrien S. Januar, MD, PhD Res-000 3/27/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Baltimore, MD 21224 (Johns Hopkins Bayusen Medical Chi

4940 Eastern Ave

2007

gistrar's Signature

Januier,

APR 03

31. Date filed (Month, Day, Year)

			1 - State of Maryland / Dep	artment of Health and Nertificate of Death		. / 11 11 /	10449
b	Dhyoloi		Decedent's Name (First, Middle, Last)	Timouto o. Dou	2. Date of Deatl		3. Time of Death
-	Physici /Medi		Joanne M. Kramer		March 3	0, Day 2007 Year	8:44 рм
. s ve	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
-	Funeral		Upper Chesapeake Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Bel Air If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Harford	ce (State or Foreign
à	Director		219-38-1164 1 M 2 XF 65 Yrs.	Months Days Hours Min.	4/30/19	Year) Country 41 Mary I	and
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			
	Maryl I-f sho fied a	tor	MD Harford Forest			100	. Inside City Limits 1 ☐ Yes 2 🔀 No
	th the or 28a e noti	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country	?
	ath wi	ral	910 Bernadette Drive	21050		USA	
	ter de items iner m	Funeral	11. Marital Status  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Ves 2 1 □ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc	
200	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	þ	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 【 No Specify:		Specify: Whit	e
ည	72 ho "natur dical	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	ina 1	16b. Kind of Business/Indus	stry
9500-61212	within ene. than he Me	dmo	College (1-4075+)	ekind of work done during most of work DO NOT use retired) Home Maker	9	Own Home	
	l be filed within 72 h ntal Hygiene. ed other than "natu event, the Medica	Be Cc	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M		
/land	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Informatir if time 72 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To B	Amadeo Liberatore	Carmela	DiPasqua	1e	
=	2 sho l and l is ma rauma			ng Address (Street and Number or Run			
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	Pages nent of I int: If ite iry or o		1X Burial 2 Cremation 3 D Removal from State cemetery, cre	psition (Name of matory or other place)  Of Faith Cem. 4/3/		altimore, Mai	
Daltimore	permit. F Departme Importar any Injur once,	1		2. Name and Address of Facility		more, Maryla	
٥	a iii De		Melin all	eonard J. Ruck, In	c. 5305	Harford Road	nu 21214
			23a. Part1. Enter the disease, or complications that consed the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o		st, Ar	proximate terval Between
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. HYPTRTROPHI(	CARDIOMY	LOPATH		nset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
-	and transi	Examiner	that initiated events  c.				
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The law requires that the death conflicts to account	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome pf pregnancy   1 □ Live birth   2 □ Fetal death   3 □	Ectopic pregnancy		23d. Date of delivery	
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	as bee	plete			24a. Was an	24b. Were autopsy	findings available
P P	page	Completed			autopsy performs 1 Yes 2	prior to comple	etion of cause of
lejan.	certific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death			
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dipo	ath. r: Afte ie fune	ation	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
r Atte	lrecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str. building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Ro	oute Number,
oital o	urs aft	Se				,	
e Hos	within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ledical	29a. Certifier (Check only one)  Medicai Examiner: On the best of my knowledge, death 2 Medicai Examiner: On the basis of examination and/or in and manner stated.	occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner as stated te and place, and due to the	d, e cause(s)
Toth	To the		29b. Signature and little of certifie	29c. License number	29d	Date signed (Month, Day,	, Year)
)	1		SYEDAH S. GILANI.	M. D. 4 6667	AF	PRIL 2 2	007
8			30. Name and address of person who completed cause of death (Item 23a) (Type,				
	Stat	e	31. Date filed (Month Day, page 2007 32 Begistrar's Signature	122 OLD EMMOR	10N KOA	D SULTERIZ	
	Registra		AFR 0 0 2001 Between St. Age				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month 7.00 PM **Physician** larc 30 200 Janet Martha King /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Anne Baltimore Washington Medical If Under 1 Year 8. Date of Birth (Month, Day, Year) 04/04/1943 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗓 F PA 63 161-34-2361 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21061 305 Wilson Blvd. SW by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 K No Specify: Specify: NIPA Janet Baltimore, Maryland 21215-0036 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Be Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Feight Russell Snyder ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 279 Roesler Avenue; Glen Burnie, MD 21061 Mrs. Janine Thomas /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2☐Cremation 3☐Removal from State Maryland Vets. Cem. 04/03/2007 Crownsville, MD 4 Bonation 5 Other (Specify, 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or corollications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OVARIAN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mis 10 Name and address of person who completed cause of death (Item 23a) (Type, Print) gleu Burnie mo 20161 Hospital Drive 301 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / De State Amend #7, 18, perFH, g866, 4/3/07 TT	partment of Health	n and Mental Hy	giene	10151
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	arylar show	-	10a. State 10b. County 10c. City, Town o				10d. Inside City Limits
	the M 28a-f lotifie	Director	MD BALTIMORE OWINGS  10e. Street and Number	MILLS			1 ☐ Yes 2 ☐ No
	3a or	i	8 INDIAN PONY COURT	10f. Zip Code 21117		10g. Citizen of What Co. U.S.A.	untry?
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic ( If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No-	14. Race - Amei	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give X Year or Dates:	1 ☐ Yes 2 No Speci		Black, White	white
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DIVISION OF	al or Attend after death I Director: / d in by the f	fical	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm,	21		treet and Number or Rur	al Route Number
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	To the complete compl	Me	29b. Signature and title of certifier	29c. License number	7 2	9d. Date signed (Month,	Day, Year)
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DHMH 17 Rev 1/2001

ORIGINAL

Northwest

Registrar's Signature

**ORIGINAL** 

Boston

31. Date filed (Month, Day, Year)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1- State Amend #9, 11, perFH, 6866, 4/3/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $2007^{\text{Year}}$ 30<sup>Day</sup> MARCH **Physician** KAPLAN 12:30 A M LEON /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/18/1922 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F NY 84 215-14-5744 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No BALTIMORE OWINGS MILLS Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4730 ATRIUM COURT APT, # 206 21117 .A. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after 1 TYYes 2 No If Yes, Give Year or Dates: WHITE 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) APPRAISER STATE OF MARYLAND permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **HURDUS** KAPLAN CELIA **ABRAHAM** HYMAN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2715 WOODLAND ROAD - EVANSTON, IL 60201 LIBBY HILL / SISTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Important: if it any injury or o CARROLL CREMATION INC. 04/02/2007 HAMPSTEAD, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 July 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eas **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-transit Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year in the past 12 months? Month Day 1 ☐ Yes 2 ☐ No the 9 Unknown à signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No funeral director, page 2 should Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performe Yes 22 Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE No. ို 1 Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Manner of Death
1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation the Hospital or Attending 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) owsatown Blud/Balto taulenes ND State Registrar

28,

KENNEY

WILLIAM

07-02258	
Richard Lyne	

Richard Lyne		State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death  Reg. No. 2077										
Physicia Medical Exami		Decedent's Name (First, Middle,     Richard Michae	,			<del>_</del>		2	2. Date of De Month March 24	ath Day 2004 200	ار <b>7</b>	3. Time of Death 0629 hrs
		4a. Facility Name (if not institution, 41 Fort Hoyle Road	give street and number	-)	4	b City, Town, o	or Location o	f Death		4c. County of		1
Funeral			. Sex 7. A	ge (In yrs last I	birthday)	If Under 1 Ye	ear If Unde	r 24Hrs.	8 Date of B	irth (MM/DD/YYYY		
Director		219-60-8484	11X M 2 F	52	Yrs.	Months Da	ys Hours	Mın.	June	3, 1954	Foreig Co	<sub>untry)</sub> Maryland
uy		Usual Residence of Decedent  10a. State 10b. County		10c. City, Toy	wn or Locatio	on						10d. Inside City Limits
nd how a	_	Maryland Harford	3	Joppa								1 Yes 2 No
Maryland 28a-f show any 1 at once,	Director	10e. Street and Number		1 11		10f. Zip Code				10g. Citizen of Wh	at Cour	ntry?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Ö	41 Fort Hoyle F				21085				USA		
eath wi	Funeral	11. Marital Status  1 Never Married 2 Married 2	12. Was Deceder	?	13. Was	Decedent of H s, specify Cuba	lispanic Origi an, Mexican,	in? ( Spe Puerto R	cify Yes or Ni lican, etc.)	0- 14. Race White		can Indian, Black,
fter d	by Fu	3 Widowed 4 Divor	1 Yes 2  Ced If Yes, Give Year or Dates:	No No	1	Yes 2 <sub><b>X</b></sub> N	o specify			Specify:	Wr	nite
hours.		<ol> <li>Decedent's Education (Specification)</li> <li>Elementary/Secondary (0-12)</li> </ol>	y only highest grade co College (1-4 or			s Usual Occup st of working lit				16b. Kind of Bu		
036 thin 72 ne. r than tedical	Completed	Elementary/Secondary (0-12)	4		etect:	ive						office
ore, MD 21215-0036 ss I and 2 should be filed within 72 hours a of Health and Mental Hygiene. If item 27 is marked other than "natural her traumatic event, the Medical Examin		17. Father's Name (First, Middle, La	ast)				18 Mother's	Name (	First, Middle,	Maiden Surname)		
212: uld be l Mental marke	o Be	Richard Albert 19a. Informant's Name/Relationship	Lyne (Type, Print)	<del>- 1</del>	19b. Mailing	Address (Stre	Mari eet and Numb			Brady mber, City or Town	n, State	Zip Code)
MD id 2 sho ulth and m 27 is aumati		Brenda Ann McLau	ghlin-Lyne	/Wife	41 I	Fort Ho	yle Ro			, Marylaı	nd 2	21085
Tore, MD 2 ages I and 2 shou nt of Health and Int. If item 27 is not the traumatic		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from S		e of Disposit natory or othe	ion (Name of c er place)	emetery,		Date	20c. Location -	City or	Town, State
Baltimore, permit Pages I at Department of He Important: If ite		4 Donation 5 Other Spec		Mour	ntain (	Christi	an Cen	n. 3-	-29 <b>-</b> 07	Joppa,	Mar	yland
Ba perm Depa inju		For MIL	1h		1 1.	me and Addre CCOMAS 317 Cok	esbury	7 Roa	ad, Ab.	ınqdon, I	Mary	land 21009
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Examiner	Contact gunshot wound of head										Death	
		Sequentially list conditions,	b									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence of):								
ted 1 ansit		events resulting in death) Last	Due to (or as a cons	equence of):								
50, te be executed nysician and burial - transit	edical	X UNPENDED	AMENDED #2	<b>per ne</b> 3a,27,28a	<b>g866</b> -1, peri	<b>4–4–07</b> Æ, g866	<b>vt</b> 4/5/07	7 TT				
Box 68760, death certificate be the attending physic d for use as the but	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnand		il death 3	Ectopic	pregnanc	Э	23d. Date of Month		ay Year
30x 6876 death certificat e attending phy for use as the	Physician/M	past 12 months?  1 Yes 2 No 9 Unknown		t time of death		er (Specify)						
D. B. t the de by the	1	Part II. Other significant condition	9OHKHOWH	th but not result	ting in the un	derlying cause	given in Par	t I.	23e. Did t	obacco use contrib	oute to 1	the cause of death?
s, P.O.	d by								1 Ye	s 2 No 3	Prob	ably 4 🗸 Unknown
of Vital Records, g Physician: The law requir iffer this certificate has been s neral director, page 2 should	Completed	W							24a. Was	psy p		topsy findings available ompletion of cause of
tal Rec	S								1 🗸 Yes		<b>✓</b> Ye	s 2 No
Vital Rec ysician: The his certificate director, page	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpati	ent 2 ER	/Outpatient		Other	-	-	Residence 6	Other	: Scene
n of \ ling Phy After th	$\vdash$	27. Manner of Death	28a. Date of Inj (Month, Day,	ury 281	b. Time of Inj		ury at Work?		8d. Describe	how injury occurre	∍d	
Division fal or Attendi rs after death al Director:	catio	1 Natural 5 Pendin 2 Accident Investig	pation Fnd 3/24/	2007 F	nd 6:15	am	Yes 2 X			: shot self		ral Route Number, City
Divipital or /	ertification:	3 X Suicide 6 Could r		ound in v			building, etc		or Town.			
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phe completely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier (Check only 1 Certifying Physical Certification Certi	sician: To the best of n					e, and d	ue to the cau	se(s) and manner	as state	ed.
To with	Med	29b. Signature and title of certifier	and manner stated			29c. Licer	ise number			29d. Date signe	d (Mor.	nth, Day, Year)
		The other	4. 16.01	TRUE	and.	0.0	.M.E.			March 24, 2	2007	
	1	30. Name and address of person with Theodore M. King, Jr., N		death (Item 23a	3)	11 Penn S	treet. Balt	imore	MD 2120	1		118
. St	ate	31. Date filed (Month, Day, Year)	Registra	ar's Signature								
Regist	rar	APR 0 2 20	11 AS 9.00.00	H.	Arrell.							

ORIGINAL

		•	For Stata Registrar	State of I	Marylan		artment tificate			and M	ental Hy	/giene	0007	position mind	45	5
	Physici	20	Decedent's Name (First, Middle	a, Last)							2. Date of Do Month	eath Day	y Yea		e of Dea	th
	Physici /Medic		Bertha Dolores				45 Ob. T.		Lasalias	5 D - 4 h	April		2007 County of De	081	15	М
	Examin	er	4a. Facility Name (If not institution		er)		4b. City, To		Location o	or Death						
	Funeral		Riverview Care 5. Social Security Number	6. Sex 7.	Age (In yrs. I	last birthday)	Esse	Year	If Under 2	24 Hrs.	8. Date of Bi (Month, D	rth	altimo	re Birthplace (Sta. Country)	te or Fo	reign
	Director		213-18-7509	1□M 2 <b>7</b> F	84	Yrs.	Months	Days	Hours	Main.	07/01			aryland		
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City	y, Town or Lo	cation							10d. Inside	City Li	mits
	Maryli f sho	ţ	Maryland Balti	moro	Fcc	sex								1 🗆 Y	res 2	No
	r 28a	Director	10e. Street and Number	more		sex	10f. Zip C	ode			-	10g. Cit	izen of What	Country?		
	th wit	ai D	1 Eastern Blvd				212	21_					ted St			
	er dea	Funerai	11. Marital Status	12. Was Decede	s?	S. 13.	Was Deceder f Yes, specif	nt of His y Cubar	spanic Orig n, Mexican	gin? (Spe ı, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - Al Black, W	merican Indian 'hite, etc.	١,	
36	irs afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes Give	es:		1 ☐ Yes 2	No	Specify:				Specify:	White		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Modical Examinat minit be notified at	ted	15. Decedent	t's Education		16a. Dece	lent's Usual kind of work	Occupa done d	tion	t of workii	20	16b. K	ind of Busine			
7	ithin 7 nen "r	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	OO NOT use	retired)	aning moon	. 01 ********	.9					
	filed w Hygier other th		5 17. Father's Name (First, Middle,	l ast)		Homer	naker	— Т	18. Mothe	er's Name	(First, Middle		mestic			
Maryland	d be f antal h sed of	o Be	Joseph Ruszkie								e Byst		,			
Z Z	should nd Men smarke umatic	1º	19a. Informant's Name/Relations			19b. Mailir	ng Address (	Street a					or Town, State	e, Zip Code)		
	ealth arm 27 is		Arlene Biles -	Daughter					rive				yland :			
ore	f Item		20a. Method of Disposition  1 ■ Burial 2 □ Cremation	3 □Removal from Sta	ate	lace of Dispo emetery, crer	natory or oth	er place	I		ate		•	or Town, State		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam per must be rectified at one.		* 4 □ Donation 5 □ Other (S)  21. Signature of Funeral Service		Ho]		ary Ce				5/2007	Balt	timore	, Maryl	and	
Ba	permit. Departrimports any inju		21. Sellatile of Fullerial Selving	12/sten		Da	yid J	We	eber	Fune	ral Ho	mes I	P.A.	ryland	212	21
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory	arrest,		Approxir	mate	
	Physician		Immediate Cause (Final disease or condition		peV	ed (	'and	Je	_ (	274	hyth	m	2)	Onset a		
	/Medical Examiner		resulting in death)	Due to (of	as a consequ	uence of):	4.1	00		7	hyth seg	10		un-1	Kero	w
	LAMITHIE	<u>L</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ		7)/\	Cu	1	باحد				,		
7	nsit	Examine	cause. Enter Underlying Cause (Disease or injury	<	40 4 00004	201100 017.										
/ 	te be executed ysician and e burial-transit		that initiated events resulting in death) Last	C. Due to (or	as a consequ	uence of);										
3760,		icai		d												
x 68	The law requires that the death certifical ste has been signed by the attending phy bage 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pregna	incv		-					22d Date of	dolinon		
Вох	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birtl	n 2 ∏ Fetal tat time of de	Ideath 3□	Ectopic pred						23d. Date of Month	Day	Year	
P.O.	that the de led by the a detached t	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknow	n											
S,	w requires that s been signed b t should be deta	by P	Part II. Other significant condition	1	th but not rest	ulting in the u	nderlying cau	ISE GIVE	n in Part I.					e to the cause		
ord	equir sen si nould b		Pemphi go	u'a,	PUL	,		D	-/		11_	Yes 2			Qenkr	
Sec	has by	Completed	Mem &		-						24a. Wa auto peri	s an opsy formed?_	24b. Were prior death	autopsy findir to completion on?	ngs avai	able of
Vital Record		e Col	25. Was case referred to medical	1					Of Diago	of Dooth	1 ☐ Yes (Check only	2 No		res 20 No		
¥	Physician: r this certificand director, i	To Be	examiner?	Hospital: 1 ☐ Inp	atient 2 🗆	ER/Outpatier	it 3 DOA	Othe					6 □Other (S	Specify)		
Division of	ding Phys		27. Manner of Death	28a. Date of (Month,	Injury Day Year)	28b. Time of	28	c. Injury Work			28d. Describe					
Siol	Attending ir death. ector: Alter by the fune	catic	2 Accident investig	gation			М		′es 2 🗆		205 1	(0)	- 1 1/1 1	D (D	l. mah a a	
Ξ	or Att	Certification;	4 Homicide determ	inod   200. Place U	Injury - At ho , etc. <i>(Specif</i> )	ome, farm, str y)	eet, factory,	office				(Street ar own, State		Rural Route N	vumoer,	
	To the Hospital or Attending Physician: within 24 hours after death.  To tha Funeral Director: After this certific completely filled in by the funeral director,	-	29a. Certifier 1 Certifyin	ng Physician: To the b	est of my kno	wledge, deatl	occurred at	t the tim	e, date an	d place, a	and due to the	e cause(s	) and manner	r as stated.		
	n 24 h	edic	(Check only 2 Medical one)	Examiner: On the bas and manne		tion and/or in	vestigation, i	n my op	inion, dea	th occurr	ed at the time	, date and	d place, and	due to the caus	se(s)	
	To the To the Comp	Ž	29b. Signature and title of certifie	M.D.			29c.	License	number	7				onth, Day, Yea		
,	0		100					)^ .	38=	736	1	04	01	- 200		_
	3		30. Name and address of person		of death (Item	n 23a) (Type,	Print)	TE.	RN	03	LUD	_	M.D.	-212	2-1	
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signa	iture									,	
	Registi		APP 0 S	3 2007	Coes o	K A	call )									
DH	IMH 17 Rev 1/2	001	HI II U	LOUI JOHN	Market &	- 19										

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day MARCH 2007 **Physician** 26 CHARLES LURTLLO 4c. County of Death Howard /Medical 4b. City, Town, or Location of Death Columbia 4a. Facility Name (If not institution, give street and number)

Howard County General Hospital Examiner Birthplace (State or Foreign Country)
 Connecticut Date of Birth (Month Day, Year) March 16, 1932 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 045-24-6449 6. Sex 1 M 2 □ F Days Hours Min. **Funeral** Months Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a State 1 ☐ Yes 2 No ishow Columbia "natural", or items 23a or 28a-f shovedical Examiner must be notified at Howard Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5635 Harpers Farm Rd. 21044 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black, White, etc. 11. Marital Status Never Married 2 Married 1 ☐ Yes 2 🗷 No White Specify: Specify. Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Government Computer Analyst College41-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname)
Minnie Wilson is marked other 17. Father's Name (First, Middle, Last) Be Charles Harry Lorello Pages 1 and 2 should be nent of Health and Mental P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2. 2408 Erdman Ave. Baltimore, Maryland 21213 19a. Informant's Name/Relationship (Type. Print) Personal Rep. Mr. Brian Harryman permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Patrick's Cemetery 20a. Method of Disposition Mystic, Connecticut 04/04/07 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Liv 22. Name and Address of Facility
Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 M00535 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Incrediate Cause (Final sease or condition resulting in death) LUNG CANCER METASTATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Division or Vital Records, P.O. Box 68760, ng physician and as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate has birector, page 2 s 2 🗆 No 1□ Yes 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Empatient ို 1 ☐ Yes 2 ☐ Ho this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М To the river, within 24 hours efter deau, To the Funeral Director: Aft 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) 10 30. Name and eddress q 10700 CHARTER DA # 200 FUH JONATHAN Registrar's Signature 31. Date filed (Month, Day, Year) APR 03 2007 Registrar

07-01912 Joyce Ann Lassiter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificate of Death					Reg. No.			
Physicia Medical Exami	in/	1. Decedent's Name (First, Mid Joyce	dle,Last) Ann	L	.assiter		2. Date of Dea Month March 11,	th Day Year	3. Time of Death 0535 hrs		
		4a. Facility Name (if not institut Baltimore Washingto	· -		1 1	, Town, or Location of n Burnie	f Death	h 4c. County of Death Anne Arundel			
Funeral Director		5. Social Security Number 412-11-0111	6. Sex 7. Age	(In yrs. last bi	rthday) If Ur Yrs. Mor	nder 1 Year If Under https://doi.org/10.1001/10.0001	T		Birthplace (State or reign Country) Tenn		
Maryland 28a-f show any d at once,	Director	Usual Residence of Decedent  10a State 10b. County  Maryland Ann  10e. Street and Number	e Arundel	10c. City, Towi	adena	Ip Code		0g. Citizen of What C	10d Inside City Limits 1 Yes 2 No ountry?		
th the Ma 23a or 28 notified	al Dire	1148 Sauerbac				21122		USA	St. 1		
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	by Funeral		ivorced If Yes, Give Year or Dates:	X No	If Yes, spe	cify Cuban, Mexican,		Specify:	white		
1036 vithin 72 hou ene er than "nat Yedical Exa	Completed	Elementary/Secondary (0-12	) College (1-4 or 5	+)		rative	use retired)	X-10 Dep	ot. of Engery		
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other (than ratic event, the Medical	Be	17. Father's Name (First, Middl Maurice	Ritte	nhouse		V	Name (First, Middle, I	<u> </u>	East		
and 2 should leath and Me tem 27 is mater and me traumatic entraumatic entra	2	19a. Informant's Name/Relation Vera Rittenho	ship (Type, Print ) USE		543 La	urel Road	clinton T	N 3//16			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- injury or other transmatte event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 XBurial 2 Crematic  4 Donation 5 Other  21. Sign- ure of Funeral Service	Specify:	te crema		orial and Address of Facility	3/16/07 Stallings Road Pasade	Clinton Funeral	TN Home P.A.		
Physician /Medical Examiner		23a. P. rt I. Enter the disease, callure. List only one caus Immediate Cause (Final diseasor condition resulting in death)	e on each line.	ne intox	not enter the mod		rdiac or respiratory arr		Approximate Interval Between Onset and Death		
ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse								
760, icate be executed physician and the burial - transit	edical	X UNPENDED			ME, G866,	4/5/07 TT					
ox 68 cath certifications as as	ΣΙ	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9  ✓ U	4 Pregnant at t			th 3 Ectopic pecify)	pregnancy	23d. Date of deliving Month	ery Day Year		
i, P.O. B ires that the d signed by the	þ	Part II. Other significant cond	itions contributing to death	but not resulti	ng in the underlyi	ng cause given in Par		2 No 3 F	to the cause of death?		
Division of Vital Records, P.O. tal or Attending Physiciau: The law requires that the safter cleath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed					OS Please of Death (	1 🗸 Yes	prior death			
ital iician s certi	Be	25. Was case referred to medic examiner?		nt 2 🗸 ER/0	Outpatient 3	26.Place of Death (		Residence 6 Ot	her:		
n of V ding Phy: h. After thi funeral d	on: To	1 Yes 2 No  27. Manner of Death  Natural 5 Pei	28a. Date of Injur (Month, Day,Ye	y 28b	. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred			
Division of Vital Rec To the Hospital or Attending Physiciau: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	2 Accident Inv 3 Suicide 6 X Co		Rural Route Number, City  Pasadena, MD							
the Hospi hin 24 hot the Funer	ledical C	29a. Certifier 1 Certifying	Physician: To the best of my aminer:On the basis of exam				ce, and due to the caus	se(s) and manner as s	tated		
To virin	Mec	29b. Signature and title of certification	and manner stated		2	9c. License number O.C.M.E.		29d. Date signed (i			
×			n who completed a use of deputy Chief Medical Ex			eet, Baltimore, N	/ID 21201				
St		31. Date filed (Month, Day, Year	2007 32. Registrar	s Signature	prile						

07-02220 Chand Ann Ma		Please Type or Print in Black Indelib	le Ink. Ensure All Cop	ies Are Le	egible.	
Cheryl Ann Mo	orm	State of Maryland / Departmen	nt of Health and Mental I	Hygiene		T 1 (1   T
		Registrar Certificat	e of Death		Reg. No. 200	7 1045
Physic Medical Exan				2. Date of De	ath	3. Time of Death
6	IIIIe	Chery1 Ann Lacks Moorman  4a. Facility Name (if not institution, give street and number)		March 22	Day Year 2, 2007	1928 hrs
E.		907 Honeywood Place	4b. City, Town, or Location of Dea	ith	4c. County of Deatl	
Funera			Essex		Baltimore Cou	*
Directo		7. Ago (III yi s. last birtild	Months Days Hours M	in i	Birth (MM/DD/YYYY) 9. Bir Foreig	
	ļ	230-98-8604 1 M 2 F 47  Usual Residence of Decedent	Yrs.	July		ountry) VA
any		10a. State 10b. County 10c. City, Town or	Location			10d Inside City Limits
<b>*</b> .	-	MD Baltimore Essex				1 Yes 2 X No
daryland 28a-f show 1 at once,	1 55	10e. Street and Number	10f. Zip Code	_	10g Citizen of What Cou	
ith the Maryland 23a or 28a-f sho notified at once.	Director	907 Honeywood Place	21221		USA	nu <b>y</b> ?
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at one	eral		3. Was Decedent of Hispanic Origin? (	Specify Yes or N		can Indian, Black,
death ir ite	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerl	o Rican, etc.)	White, etc.	carringian, black,
after all", o	≲ا	3 Widowed 4 X Divorced If Yes, Give Year	Yes 2 X No specify:		Specify: Bla	ack
hours "natur			edent's Usual Occupation (Give kind of	work done	16b. Kind of Business/l	ndustry
را ا	흥	College (1-4 of 5+)	ng most of working life. DO NOT use re	tired)		
5-0036 led within 72 Hygiene. other than '	Completed	12 P1	civate Care		Nursing	
filed filed ed ord t, the					Maiden Surname)	
21215-0036 buld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Josephus James Lacks  19a. Informant's Name/Relationship (Type, Print)  19b. N	Doroth	y Grinn	an	
MD 21 d 2 should ith and Mei n 27 is man	-		ailing Address (Street and Number or			_
		20a. Method of Disposition 20b. Place of D	39 Mayfield Ave.,	Date	re, MD 2121	-
DOF ages I nt of I t: If		1 X Burial 2 Cremation 3 Removal from State Lacks	or other place) Family		250. Eddallori - Oity of	TOWIT, State
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr				27-07	Clover,	VA
Ba Perm Depo		2/2 1/2//			Funeral Hom	
Physician		23a. Part I Enter the disease, or complications that caused the death. Do not en	2000 N.Main Stre	or respiratory arr	est shock or heart	A 24592 Approximate Interval
/Medical	1 9	landle. List only one cause on each line.		o. roophatory arr	ost, shook, of fiedit	Between Onset and Death
≛xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		_		Dealit
		Sequentially list conditions, b				
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Sox 68760, leath certificate be attending physicia for use as the buria	sician/Med	1 Z3C. If ves. outcome of pregnancy	ть, goo, 4/20/0/ 11		23d. Date of delivery	
68 certif nding se as	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregna	ancy	Month Da	ay Year
Box 68760, edath certificate be the attending physic of for use as the bur	ysic	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)			
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ords, P.O. w requires that the second of the	d b	Cocaine use		1 Yes	2 No 3 Proba	ably 4 🗸 Unknown
rds requi	Completed			24a Was	an 24b. Were auto	opsy findings available
eco ne law te has ge 2 s	Ę				med? death?	mpletion of cause of
		25. Was case referred to medical	20 Bloom ( Barris (0)	1 Yes	2 No 1 Yes	2 No
Vital hysician: this certiful director,	Be c	examiner? Hospital:	26 Place of Death (Check ient 3 DOA Other Mursin		Residence 6 🗸 Other:	0
ion of Vital Records, tending Physician: The law require tor: After this certificate has been si the funeral director, page 2 should b	5	27. Manner of Death 28a Date of Injury 28b. Time			now injury occurred	Scene
_ E ^ E _	흵	Natural 5 Pending (Month, Day, Year)  2 Accident Investigation Fnd 3/22/2007 Fnd 7	:25 pm 1 Yes 2 X No	unk	,,	
Division tal or Attendir rs after death al Director: A	<u>[2</u> ]	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm,	· 20 pm		Street and Number or Rura	al Route Number City
Display of the state of the sta	Certification:	4 Homicide determined (Specify) other scene			tate) ywood Pl. Essex	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	alc	29a Certifier (Check only) Certifying Physician: To the best of my knowledge, death o	ccurred at the time, date and place, and			
To the H within 24 To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	igation, in my opinion, death occurred a	t the time, date	and place, and due to the	cause(s)
L > F 3	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)
		Celille TK-	O.C.M.E.		March 23, 2007	
- 24		30. Name and address of person who completed cause of death (Item 23a)				
Ý			enn Street, Baltimore, MD 21.	201		
St	ate	31. Date filed (Manth Paylyear) 2007 32 Registrar's Signature	metho)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5 perFH G866 4/10/07 WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Үөаг **Physician** 110 24 Barbara /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, 1 2-21) Examiner 6010wax Her 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Nu**9687** 6. Sex **Funeral** 321-34 Gel Usual Residence of Decedent 1 ☐ M 2 🕻 F Yrs. Director 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28e-f show other treumatic event, the Medical Evandriar must be notified at 1 Yes 2 No Be Completed by Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 601 USA items 23a Pages 1 end 2 should be filed within 72 hours efter death vent of Health and Mental Hygiene. ent of Health and Mental Hygiene. ent: if item 27 is marked other than "naturel", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Blac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ses Star 18. Mother's Name (First, Middle, Maiden 17. Fathe 's Name (First, Middle, Last) TICK brothe 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prky Liband 20b. Place of Disposition (Name of cemetery, crematory or other p Hher cha Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 20c. Location permit. Pages 1 Department of H Importent: If Ite any injury or ot once. King Memoria 07 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee lun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) crationasinia Physician /Medical Due to (or as a consequence of): **Examiner** CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-transit HM Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. P cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 SNo To the Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ٩ 1 ☐ Yes 2 No 4 Nursing Home 5 ★ esidence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation WIX 2 ☐ Accident hours after deat uneral Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DOWISWOMER 10005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 DC N. Charles 6 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 3 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MILLER 0041 SANDRA 01 04 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel General Hospital Annapoli If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/16/1945 Birthplace (State or Foreign Country) n yrs. last birthday) **Funeral** Days 1□M affir 61 Virginia 204-34-5387 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State at a or 28a-f sh 1 ☐ Yes 2 X No Ebensburg Pennsylvania Cambria Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 15931 158 Horseshoe Drive United States Items 23a **Examiner must** Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Narried Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monee. Record Keeper Heating & Plumbing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell D. Page Romaine L. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Miller / Husband 158 Horseshoe Drive Ebensburg, PA 15931 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/02/2007 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Dicense 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that the death certificate be executed iding physician and se as the burial-trar ated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown signed by t 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 2 12 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 Nnpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) ဥ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident To the Funeral Director: completely filled in by the i 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21438 0 ſ 30. Name and address of person who confipleted cause of death (Item 23a) (Type, Print ENSE Highwan m 445 ENTA NICHAME gistrar's Signature 31. Date filed (Month, Day, Year) State APR 03 2007 Registrar

Physicia /Medica		Desertable Name (First Middle Last)			tificate of L		2. Date of Deat	eg. No	~	3. Time of Death
	n	. Decedent's Name (First, Middle, Last)			Month	Day	Year <b>2007</b>	6:30 A		
	al _	FREDA YVONNE MILLER  a. Facility Name (If not institution, give street	at and number)		4b. City, Town, or	Location of Death	PARCH -	-	ty of Death	0.50 1.
Examine	er 4		and nombony	l.	CATONSVILI			BALTI	MORE	
	5	CATONSVILLE COMMONS Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Forei
Funeral Director		219.28.5772	2 <sup>th</sup> F 73	Yrs.	Months Days	Tiours IIIII	AUGUST 18	3, 1934		KY
	-	Jsual Residence of Decedent	10c City	. Town or Lo	cation					10d. Inside City Limi
show d at	_	Oa. State 10b. County								1 □ Yes 2 □ I
8a-f	Director	MD ANNE ARUNDEL	GLEN	BURNIE	10f. Zip Code		11	Og. Citizen o	f What Cou	
be n		IOe. Street and Number			21061				USA	
ns 23	eral	1135 MCHENRY DR.	Was Decedent Ever in U.S	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No-	14. R	ace - Amer ack, White	ican Indian,
Department of Health and Mental Hygiene. important; or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2XX No	Specify:	nican, etc.)	Spec	cify:	ITE
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han 'e	ld m	Elementary/Secondary (0-12)		SECRETARY/A			MEDICA	L EQUI	PMENT	
her th	ပိ	12 17. Father's Name (First, Middle, Last)		L	JEORE IIII.					
ed of	Be					ALKA RICE				
and Mental I s marked of umatic eve	<b>P</b>	PROCTER PICKELSIMER  19a. Informant's Name/Relationship (Type.	Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or Tow	ın, State, Z	(ip Code)
th an		IRVING J. MILLER	HUSBAND	1135	MCHENRY DR	. GLEN BURN	IIE, MD 210	061		
Hear tem other	13	20a. Method of Disposition	20b. P		osition (Name of ematory or other pla		Date	20c. Locatio	n - City or	Town, State
y or		1 XX urial 2 □ Cremation 3 □ Rerr 4 □ Donation 5 □ Other (Specify)	ioval from State I		CROWNSVILLE		2007	CROWNSV	ILLE,	MD
Department of the poorting of		21. Signature of Funeral Service Live see	e de la companya della companya della companya de la companya della  F F	2. Name and Addre INK FUNERAL 26 CRAIN HW	ess of Facility HOME, P.A.	HIDNIE MIN	21061			
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e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√1 No 9 □ Unknown	: If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fetr 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3	□Ectopic pregnan	су			Date of de Month	Day Yea
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ate has been page 2 should	Completed						1□ Yes	psy ormed? 2No	4b. Were a prior to death? 1 ☐ Ye	utopsy findings ava completion of caus s 2 \( \sum \text{No} \)
this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	spital: 25		==		ath (Check only		Oth == /0-	aciful
	. To	1 ☐ Yes <b>XX</b> No	28a. Date of Injury	28b. Time	of 28c. Inj		Home 5 ☐ Res 28d. Describe			cony/
r death. ector: After by the funer	Certification:	1 XXNatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)  28e. Place of injury - At I	Injury	M 1	Mork?  M 1 □ Yes 2 □ No  Teet, factory, office 28f, Location (Street and Number or Rural Route Number)				
a i te	Certif	4 Homicide determined	building, etc. (Spec	city)			M	iwn, State)	d manner	as stated.
within 24 hours af	Medical	29a. Certifier (Check only one)	clan: To the best of my kner: On the basis of examinand manner stated.	nowledge, de nation and/or	investigation, in m	y opinion, death oc	curred at the time		ace, and de	
ompl	Me	29b. Signature and little of certifier	1/11	20 00		nse number				nth, Day, Year)
7%		Jely C	Med, 1		H DOC	15641	4	4-	2-5	007 nsville, M 212
		30. Name and address of gerson who con								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician рМ 3:30 April 1, 2007 Elizabeth Anna Murphy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Oak Crest Care Center Baltimore Parkville 8. Date of Birth (Month, Day, Year) 8/07/1919 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 87 Maryland 217-03-2888 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No r 28a-f sh notified MD Baltimore Parkville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene.
Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be none. USA 8832 Walther Blvd. 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Backert Anna J. Buedel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. John Schieve PMB 2809 Son P.O. Box 2430 Pensacola, FL 32513-2400 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer Cem. April 4, 2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5305 Harford Rd 21. Signature of Funeral Service Licensee Kimperly Davidson Leonard J. Ruck, Inc. Baltimore, MD 21214 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Bacterial **Physician** phenmonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical as IF FFMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Atrice Fibrillation 1 Tyes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes autopsy performed page Denewhil 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ٩ 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

and I-transit that the death certificate be executed physician a s the burial-Division or Vital Records, P.O. Box 68760, attending p the s been signed by should be detac has certificate Physiclan: After this or Attending Director: /

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospin...
within 24 hours after
To the Funeral Dir

Medical State Registrar

29 a. Certifier

(Check only

31. Date filed (Mont)

29b. Signature and title of certifie

riven

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Washer Bud Rankwill MDSHBY

euse of death (Item 23a) (Type, Print) 30. Name and address of person who completed

and manner stated.

JND 8800

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2<sup>Day</sup> Month Physician 200°7 April 10:40 a<sup>M</sup> Arthur F. Martin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore** Oak Crest Care Center Parkville If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, JUL 3, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 X M 2 □ F 219-36-9330 97 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Baltimore Parkville Parkville MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a or USA 8820 Walther Blvd., Apt. CC-507 21234 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland Dept. College (1-4or 5+) Elementary/Secondary (0-12) of Agriculture Food Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Feh1 John Martin 2 other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 812 Steeplechase Lane, Martinsburg, WV 25404 Iris Heichel - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If ite any Injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 4/3/2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H., Williams <sup>22. Name and Address of Eacility</sup> Cremation Society of Maryland, 299 Frederick Road, Baltimore, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** infarction myocardial disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 5 Other (specify) signed by the a d be detached f 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? eibrilla tron 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hhknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has t autopsy perform 1□ Yes 2 INO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) Certification: To eral Director: After thi filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 Pending 1 ∏Yes 2 ∏No investigation death 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mos D58646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walther Boslavard Monies Anna 4400 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar		, , , , , , ,	Certificate of L	Death		Reg. No. 2007	10465		
	Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	ath Day Year	3. Time of Death		
	/Medic	100	Alma	Erse	lla		ginson	03	27 200			
	Examin	er	4a. Facility Name (If not institution, g				Location of Death		4c. County of Dea			
			Sunrise Assis 5. Social Security Number 6.		n yrs. last bii		sville If Under 24 Hrs.	8. Date of Birt	Baltim	ore thplace (State or Foreign		
An	Funeral Director		214-40-9551 Usual Residence of Decedent	1 □ M 2 1 1 F	64	Yrs. Months Days	Hours Min.	(Month, Day )5 26	v, Year) C	ountry) VA		
	nand ow at		10a. State 10b. County	10	0c. City, Tow	n or Location				10d. Inside City Limits		
	Mary t-f sh fied	to	MD NA		Bal	.timore				Y∏Yes 2 □ No		
	or 28s	ired	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?		
	23a ust b	Funeral Director	119 South Tre	mont Road			L229		U.S.A.			
	tems	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	. 14. Race - Am- Black, Whi			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4√ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify:	Black		
Maryland 21215-0036	2 hou atura cal E		15. Decedent's	Education	16a	. Decedent's Usual Occup	ation	1	16b. Kind of Business	/Industry		
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21	ed wit ygien ygien ter th	Completed	12th_grade	na	D	irector of			Conventi	on		
pu	be file	Be	17. Father's Name (First, Middle, La.	st)			18. Mother's Name	, , ,	,			
<u>\sqr</u>	ould Men narke	유	Inerson T. Me  19a. Informant's Name/Relationship		101	o. Mailing Address (Street	Eileen			7:- 0-4-1		
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စ်	Heal Heal tem 2		Dante Brooks- 20a. Method of Disposition	son	20b. Place o	721 Avatar of Disposition (Name of ery, crematory or other place	Lane,	Jwings ate	20c. Location - City of	r Town, State		
3altimore,	Pages ent of ht: If i		1 ☐ Burial <b>2√</b> ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemoval from State		Crematory or other place	1	28/07	Paltimor	o Ma		
alti	mit. Foortan		21. Signature of Funeral Service Lic		Metro	22. Name and Address March F/H	ss of Facility	20/07	Barcimore	e, Mu		
m	permi Depar Impor any ir		Xola N	Tarch		4300 Waba	ash Ave,	Balti	more, Md	21215		
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98	ertificat ing phy e as th	Medical	IE ECHAIC.									
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ţ		Be C	25. Was case referred to medical				26. Place of Death			3 2 110		
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Ξ	or At after of Direct in by	Certification:	4 ☐ Homicide determine	d building, etc. (	Specify)	arm, street, factory, office	2	City or Tou	Street and Number or F vn, State)	tural Houte Number,		
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.			Physician: To the best of n								
	n 24 h	edical		aminer: On the basis of ex and manner stated	camination a							
	To the within To the Correction	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor			
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	3		30. Name and address of person when the state of the stat	bery 22	7 >+		Bulton	rd 7	U202			
ş.	Sta Registi		31. Date filed (Month, Day, Year) APR 0 3	2007 32/Registrar's	Signature	parle						

DHMH 17 Rev 1/2001

amar Mackie		State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg No.	7 1046
Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death	3. Time of Death
Medical Examir		TAMAR MACKIE March 31, 2007	1809 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Northwest Hospital Center  Ac. County of Death  Randallstown  Baltimore Cou	i
Funeral	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth	
Director		110-66-2270 1XM 2 F 24 Yrs. Months Days Hours Min. NOV. 10, 1982 Foreig	untry) NEW YORK
á	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
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ne Maryland or 28a-f show any fied at once.	Director	10f. Zip Code 10g. Citizen of What Cour	itry?
ith the 23a or			ean Indian Rlack
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she ral Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ameri White, etc.	sar muan, black,
after de	by Fi	No specify: Specify:	ACK
hours afte "natural", Examiner	fed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/I during most of working life. DO NOT use retired)	ndustry
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215-0036 be filed within ? ntal Hygiene rked other than ent, the Medica			2 1
S Me ald	o Be		Zip Code)
Baltimore, MD 2 pernit Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic	_[	VICK RICH (MOTHER) 824 STAMFORD RD. BALTIHORE, I	4021229
or Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or	Town, State
Baltimore, permit Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specify: KING MEM PARK 04-05-01 W000LAW  [21. Stignature of Funeyal Service Licensee]  [22. Name and Addgess of Facility (Recorded to the Specific Control of Specific	V. MARYLAND
Balt permit Departi Importi injury	ľ	21. Signature of Funeral Service Licensee Pour Parent 22. Name and Address of Facility BROWN R. FUNER	AL HOME 10. 21217
Physician	7	Part I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arfest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and
Medical. Examiner	U	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Death
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	Examiner	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause	
, eq	Exan	(Usease or injury that initiated events resulting in death) Last Use to (or as a consequence of):	
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c 6876( certificate ending phy use as the b	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month  Other (Specify)	Day Year
ision of Vital Records, P.O. Box 68766 Attending Physician: The law requires that the death certificate ar death. retor: After this certificate has been signed by the artending phys by the funeral director, page 2 should be detached for use as the b	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown  Part II Other significant conditions contribution to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to	the cause of death?
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Division  To the Hospital or Attention 24 hours after decended to the Funeral Director completely filled in by the second completely filled in by the second complete of the second com	Medical	2 29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	e cause(s)
To Con	Me	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo.	nth, Day, Year)
		Patri Monica - Pollet m O.C.M.E. April 1, 2007	
2		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	ate	te 31. Date filed (Month, Day, Year) 32. Recistrar's Signature	
Regist		ar APR 0 3 2007   Marie & Agrae !	
DHMH 17 Rev 1/20	001	ORIGINAL ORIGINAL	

within 24 hours a To the Funeral C Ë

> State Registrar

APR 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of

31. Date filed (Month, Day, Year)



ORIGINAL

29c. License number

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mo

29d. Date signed (Month, Day, Year)

20602

		1	For State Registrar	State o	of Marylar		artmen rtificat			and Me		jiene eg. No.	007	10458
Ph	ysiciai	_	I. Decedent's Name (First, Middle, La		~						2. Date of Dea Month	Day	Year	3. Time of Death
_	Medica	ı I	Green Tuggle I				45 00	T	Lassina	P :	arch	31,	2007 unty of Death	3:20 A M
Ex	amine	r '	a. Facility Name (If not institution, giv Overlea Health		,		4b. City,		Location o timor			40. Coi	unity of Deatr	
Fun	aral	5			7. Age (in yrs.	last birthday)		1 Year	If Under		B. Date of Birth (Month, Day	)	9. Birth	place (State or Foreign
Dire			227-16-7458	Sex IM 2□F	84	Yrs.	Months	Days	Hours	Min.	June 8,	1922	Va	rginia
Б >		-	Usual Residence of Decedent  10a. State 10b. County		100 Ci	ty, Town or Lo	ocation							10d. Inside City Limits
the Marylar 28a-f show	la Da	.			100. 01	ty, rown or Et		. D + i.u						1 X Yes 2 □ No
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death	Examiner must be notified at	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13.	Was Deced			gin? (Speci	ify Yes or No- can, etc.)		Race - Amer Black, White	ican Indian,
36 after dea or items	륌	7	1 X Never Married 2 Married	1 X Yes	10 T942	-	1  Yes	V	Specify:	, , , , , , , , , , , , , , , , , , , ,	out, otor,			
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Division of Vital Records, P.O. Box 68760, Content to the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and	completely filled in by the	Medical C	29a. Certifier (Check only one)  Certifying P  Certifying P  Certifying P	miner: On the I										
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	1		30. Name and address of person who	completed cau	ise of death (Ite	m 23a) (T/pa	Print	n /	3/00	1, 1	Salt	more	Mg	21239
	State	<u> </u>	31. Date filed (Month, Day, Year) APR 0 3 20	007	Registrar's Sign	ture	who			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year 202 PM VB ER APRIL 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDAZIS DWN BALTOMDRE HOSPITAL NORTHWESK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day,

Jan - 3 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 □ F , 1932 Maryland 75 Director 219-28-9386 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Experiments. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Baltimore Reisterstown Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 405 E. Cherry Hill Rd. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Mechanic Auto Parts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna G. Sanders Andrew Manger, Sr. ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type. Print) Cherry Hill Jun<u>e Troyer - companion</u> 405 Ε. Rd. Reisterstown, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 Cremation 3 Removal from State Lakeview Mem. Park April 4,2007 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21. Signature of Funeral Service Licensee He Pell 11605 Reisterstown Rd. Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANTERIOSCLEROSIC CARDINVASCULAN Physician /Medical Due to (or as a consequence of) **Examiner** Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 nknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed lo autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 250No 1 Inpatient > ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours at er deat 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 hor To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5411 OLD COUNT ROAD RANDAZLSTOWN,

State Registrar

FFDRO 31. Date filed (Month, Day, Year)

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Baltimore,	permit. Pages 1 al Department of Hea Importent: If item any injury or othe once.		21. Signature of Funeral/Service Licens	· *	22 M	. Name and Addres	s of Facility	me, P.A. , Abingdo	OWBOIL	s acces y	zara
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0	AX		30. Name and address of eren who co	mpleted callse of d	eath (Item 23a) (Type,	Print)	11 5-	Ma AIR Md.	214.5	-	
			31. Date filed (Month, Day, Year)	NY MAI JA	ME 16/4 (14)	IRCHVIIIE.	KG BEL	AIR Md.	21015		
	Sta Registr	_	APR 03 20	07	ar's Signarite						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Vera Christina Moody March М 31, 2007 12:58 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Year! Months Days Hours 1 □ M 2 🕅 F 220-07-1133 87 15, 1920 Director Mar. Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 1 ☐ Yes 21 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 1909 Emmorton Road Room 225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married than "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker 12 should be filed what and Mental Hygier 7 is marked other ti Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Claude Theodore Crouse <u> Lottie Gertrude Myers</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health al
Important: If Item 27 is
any injury or other trau Thomas C. McShane / Son 5785 Anderson Road, Stewartstown, PA 17363 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Grdn 4-4-07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Applice Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Immediate Cause (Final Disease **Physician** disease or condition resulting in death) oronar 20 years /Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): attending physician for use as the buria M. D. O. S. J. V. C. M. CO. 309 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 Yes 2 No 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D 35012 2 North Ave. Bel Air, Md. 21014 person who completed cause of death (Item 23a) (Type, Print) LYNCH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LINOVIC ETT march 11-110AM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 23, 1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF 208-14-9818 80 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Dundalk Maryland | Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 101 Center Place Apt. 515 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. h and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev Mary Heidig John Neidig ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Prescott Court, Havre Grace, Maryland 21078 Pietro T. D'Anna Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) April 2 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State Bayview Crematory 2007 4 Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Sture Juneral Service Lines Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Hart1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. 23a. Fart1, Immediate Cause (Final ADVANCED OVONSMANCEU LUNG CARCINONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Des 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 Ne Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Morthwest Hospital Cax 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) (Damaewamm)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

		1- For State Registrar		rtificate of			R	eg. No. 200	7 1047				
Physici edical Exam	×11 U	1. Decedent's Name (First, Middle,Last) Mark Steven Mc	Dermott				<ol><li>Date of Dea Month March 28.</li></ol>	Day Year	3. Time of Death 1605 hrs				
		4a. Facility Name (if not institution, give 6700 Old Dobbin Lane	street and number)	2	b. City, Town, or L Columbia	ocation of Death		4c. County of De Howard	ath				
Funeral Director			7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bi	rth(MM/DD/YYYY) 9. 8 1986	Birthplace (State or eign <sup>Country)</sup> England				
ne Maryland or 28a-f show any fied at once.	tor	Usual Residence of Decedent  10a. State 10b. County  Md Howard		, Town or Locati umbia					10d. Inside City Limits 1 Yes 2 No				
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 5470 Tree Frog Pl	.ace		10f. Zip Code 21045			I0g. Citizen of What C USA	ountry?				
er death with , or items 23: r must be no	Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No If Yes, Give Year	If Yo	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto		14. Race - Am White, etc Specify: Wh					
ours afte atural" xamine	ed by	15. Decedent's Education (Specify onl	or Dates: y highest grade completed)	16a. Deceden	t's Usual Occupationst of working life.	on (Give kind of w		16b. Kind of Busines					
21215-0036 uld be filed within 72 h Mental Hygiene. marked other than "n c event, the Medical E.	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	,	tudent			educat:	ion				
215- be filed ntal Hyg rked otl	Be C	Dennis McDermot	t			Jean W	allace						
ID 21 should and Me 7 is man	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Dennis McDermott (father) 5470 Tree Frog Place, Columbia, MD 2												
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date crematory or other place)									or Town, State				
Baltiu permit. Departm Importa		21. Signature of Funeral Service Licens			ame and Address	наі	ght Fu	neral Home	& Chapel				
Physician /Medical Examiner	8 8	P.O. Box 195 Sykesville, MD 21784  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic intoxication complicated by hypothermia											
Examile		or condition resulting in death)  Due to (or as a consequence of):  b.											
	xaminer	if any leading to immediate F cause. Enter Underlying Cause	oue to for as a consequence	of):									
ted A		(Disease or injury that initiated =	Due to (or as a consequence	of):		<del></del>	-						
e execute cian and rial - tran	dical	X UNPENDED	AMENDED, 27, 28a-f,	. perME g8	366, 4/26/0	7 TT		-					
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pred 1 Live birth 4 Pregnant at time of d	gnancy 2 Fe	tal death 3 [	Ectopic pregna	incy	23d. Date of delive Month	very Day Year				
O. B. that the de ned by the detached f	Phy		contributing to death but not	resulting in the u	underlying cause g	iven in Part I.			to the cause of death?				
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Vital hysician this cert	To Be	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	: 3 DOA	Other Nursir	ng Home 5	Residence 6 0	ther: Scene				
on of Vit nding Physic th. After this of		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of	1 1 1	ry at Work? /es 2 χ No	28d. Describe	how injury occurred					
Division of Vital Records, To the Hospital or Attending Physician: The law requin within 24 hours after death. To the Funeral Director: Completely filled in by the funeral director, page 2 should by	Certification:	2 Accident Investigation 3 Suicide 6 X Could not lead to determined	28e. Place of Injury - At	Fnd 4:0 home, farm, streend in wood	et, factory, office b			(Street and Number of State) 6/00 010	Rural Route Number, City 1 Dobbin Ln.				
To the Hospi within 24 hou To the Funer		29a. Certifier 1 Certifying Physici	an: To the best of my knowle On the basis of examination	dge, death occu	rred at the time, da	ne time, date and place, and due to the cause(s) and manner as stated my opinion, death occurred at the time, date and place, and due to the cause(s)							
To the Within To the Comp.	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed	(Month, Day, Year)				
D W )		30. Name and address of person who	completed cause of death (Ite	m 23a)	O.C.I	M.E.		March 29, 200					
D. In													

State Registrar

31. Date filed (Month, Day, Year) APR 0 3 2007

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rag. No. 2 Date of Death . Decedent's Name (First, Middle, Last) **Physician** Mard 200 /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Battimore
If Under 1 Year If Under 24 Hrs. Ba Baltimore 9. Birthplace (State or Foleign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours 1 □ M 2 XF Yrs Director Nav 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28e-f ehov the Medical Examiner must be notified at Yes 2□No by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 2/22 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 10 10 If Yes, Give Year or Dates: or Items 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married Specify: Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiged) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othen eny lijury or other treumatic event 2008. 19b. Malling Address (Street Place of Disposition (Name of 1 Surial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service L 23a. Part 1. Inter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oprosence ho /Medical Due to (or as consequence of): Examiner 10109 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and signed by the attending physicien and dbe detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions equinibilities to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SIZINO 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy performed) 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} Letrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who o impleted cause of death (Item 23a) (Type, Print)

Registrar

State

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2. Registrar's Signature

- elgelman

2007

31. Date filed (Month, Day, Year)

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	* 10	Ē	1. Decedent's Name (First, Middle, Las	t)							2. Date of D		ay Year	3. Time	of Death
	Physici /Medi	_	Eleanor Keist	er Meve	r						March	28,	2007 Year	8:00	Эрм
165	Examir		4a. Facility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location o	of Death		4	c. County of Dea	ıth	
			National Luthera	n Home				Ro	ckvil	lle			Montgor	erv	
331 <sub>41</sub> .	Funeral		Social Security Number     6. Social Security Number		Age (In yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bi	rth av. Yea	9 Bir	thplace (Stat	e or Foreign
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Maryland	2 should and Men is marks aumatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	al Route Numb	er, City	or Town, State,	Zip Code)	
-	and 2 malth martra		Irma M. Schurman	/ Sister		10977	Bals	sam S	Street	t Bi	roomfie	ld,	Co. 800	121	
<b>Baltimore</b> ,	of H of H fita rot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Bamayal from St		Place of Dispo cemetery, crer	natory or o	me of other place	e)		Date	20c.	Location - City or	Town, State	
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8760, 1/2	cate be executed / Medical and physician and ithe burial-transit	cal Examiner	a. Sequentially list conditions, if any, leading to immediate cause or individual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											ech	
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Records, 1	w requires that been signed should be def	Ď	Part II. Other significant conditions co	ntributing to deat	h but not res	sulting in the u	nderlying o	ause give	en in Part I.				use contribute le	the cause of the c	
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	h		30. Name and address of person who o	ompleted cause of	of death (Iter	m 23a) (Type,								•	
_	J		Charles Karesh, MD Nat	ional Luth	nern Har	ne Rocky	ille.	MD							
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			1 - For State Registrar	State of Ma		partment of ertificate o		Mental Hyg	iene <sub>og.</sub> Nd. 007 10476
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	Director Maryland	tor	220-38-6733 Lusual Residence of Decedent 10a. State 10b. County  Maryland Anne A		66 Yrs. 10c. City, Town or I	ocation	Millersv	Dec. 31	1940 MD  10d. Inside City Limits 1 □ Yes 2 ☑ No
	th with the 23a or 28a lat be not	Funeral Directo	10e. Street and Number 265 Najoles Road	didei		10f. Zip Code		10	Og. Citizen of What Country?
900	within 72 hours after death with the Maryland ene. than "natural", or itema 23e or 28e-1 show ha Maileal Exemiliar must be notified at	b	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		. Was Decedent of If Yes, specify C		Specify Yes or No- arto Rican, etc.)	14. Race · American Indian, Black, White, etc.  Specify: White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "natural", or itsma 23s or 28a-f show any injury or other traumatic svent, the Marical Experiment must be notified at annote.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usual Occ e kind of work doi DO NOT use reti Nurses	ne during most of w ired)	orking	6b. Kind of Business/Industry  Medical
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	s 1 and 2 s Health an Item 27 is r other traur		Walter McKenzie  20a. Method of Disposition	(spouse)	265	Najoles	Road, M	illersvill Date 2	City or Town, State, Zip Code) e, MD 21108  Oc. Location - City or Town, State
Baltimore,	permit. Pages Department of t important: If its any injury or o once.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	,	Meadowri	amatory or other p dge Ceme 22. Name and Add	etery   Mar	ch 27 2007 E	lkridge, Maryland
ä	Departing Department of the poores		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused are cause on each line	he death. Do not er	3111 MOL	untain Ro	ad. Pasade	Funeral Home, P.A.  ena, MD 21122  Approximate Interval Batween
\$ \$ a	/Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Emer ungerving	Due to (or as a	consequence of):				Onset and Death
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Records, P	w requires that been signed be should be det	þ	Part II. Other significant conditions con	IABOTE	< Mel	LITUC	given in Part I.		accoluse contribute to the cause of death?
		e Completed	A TRIAL F	IBR ILL	ATION				ZNo 1 ☐ Yes 2 ☐ No
Division of Vital	ding Phys h. After this funeral di	ToB	examiner?	ospital: 1  Inpatient 28a. Date of Injury (Month, Day		of 28c. In	ther: 4 Nursing	Home 5 Resider 28d. Describe how	ice 6 Other (Specify)
DIVIS	oital or Attenurs after deatlars after deatlars birector:	Certification:	3 Suicide 6 Could not be determined	building, etc.				City or Town,	
	To the Hospital or All within 24 hours after or To the Funeral Direct campletely filled in by	Medical	29a. Certifier 1 Certifying Physical Character 2 Medical Examinates 2. Signature and title of certifier	er: On the best of and manner state	ixamination and/or ir	29c. Lice	opinion, death occ	urred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)  d. Date signed (Month, Day, Year)
)	h 3 + 8		30. Name and address of person who co	m ed cause of dea	ath (Item 23a) (Type	Print)	4636C	/	MADCH 30, 2007 Muers well
	Sta Registr		31. Date fied (Month, Day, Year)	32. Filgistrar	s Signature	8601	oteRAn	st Gan	Muers well 21108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 7:55 p. M March 29, 2007 Marie Matilda Parson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore er 1 Year | If Under 24 Hrs. Johns Hopkins Bayview Medical Cente If Unde 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 1 F 11, 1924 Maryland Director 219-10-1862 Usual Residence of Decedent with the Maryland 10c. City, Town or Location f show 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Maryland Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1918 Larkhall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 years Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna C. Glossner Frank E. Willis, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Seabright Avenue Dundalk, Maryland 21222 Eugene P. Parson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Holly Hill Mem. Gdns. 4/3/2007 Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Avenue Dundalk, Maryland 21 on 23a Lart1. Enter the diseal of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 9 KEBRO 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was An 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No After this certificate has MON 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. 2M (cause of death (Iten 23a) Type, Print) Hegistrar's Signature 31. Date filed (Month, Day, Year) State APR 03 2007 Registrar

		•	1 - For State Registrar	State of Marylan			of Health a of Death	nd Mental H	ygiene Reg. No.	7 10479
Y.	Physici /Medic		1. Decedent's Name (First, Middle, Last) Katharin	atterso	n			2. Date of I	1 2 20	3. Time of Death
	Examin Funeral	er	4a. Facility Name (If not institution, give:  FOREST HAVEN A  5. Social Security Number  6. Security Number	Nursina He		Ca-te	vn, or Location o	4 Hrs. 8. Date of 8	Birth 9.	Deeth  NYOCE  Birthplace (State or Foreign Country)  MO
	Director		Usual Residence of Decedent  10a. State  10b. County	00	Yrs. ty, Town or L	ocation		NOV 4	1920	10d. Inside City Limits
	with the Mar Se or 28a-f s	Funeral Director	MD Baltimo		arkton	10f. Zip Co			10g. Citizen of Wha	1 □ Yes 2 ☑ No
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	t and 2 the all the arm 27 is ther trau		19a. Informant's Name/Relationship (Ty Susan P. Erickson 20a. Method of Disposition	- daughter	120 <sup>2</sup>		ost Road	l, Parkton	MD 2112 20c. Location - Cit	.0
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of Vital Records,		Completed						pe 1 ☐ Yes	topsy priormed? dea	re autopsy findings available or to completion of cause of th?  Yes 2//No
on of Vit	ding Phys h. After this funeral dii	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Other	28d. Describ	y one) esidence 6 Other e how injury occurred	(Specify)
Division	tal or Attending is after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory, of	ffice	28f. Location City or	(Street and Number Fown, State)	or Rural Route Number,
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Aedical	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, dea ation and/or in	nvestigation, in	my opinion, deal	d place, and due to the hoccurred at the time	e, date and place, and	due to the cause(s)
	Son Suite	Σ	29b. Signature and title of certifier  Ocillos  30. Name and address of person who oc	Valland Cause of death (Item	n 23a) (Tune		D 285		29d. Date signed (/	07
	Sta Registr	-	31. Date filed (Month), Day, Year)  ADR 0 3 2007	32. Registrar 9 Signar	2835	Sm	177+ F	YO SULL	£ 205,	BACP MI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5, 10f per FH G866 4/24/07 WS State of Maryland Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year Ella Mae Peterson March 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Square Hospital Rosedale 5 Social Security Number 281 - 26 - 21 00 <u>Baltimore</u> KOSCUALE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Yrs. Director APR 13. 77 1929 VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD 1 ☐ Yes 2 🙀 No Director Baltimore Dunda1k 10e. Street and Number 10f. Zip Code **21224** 10g. Citizen of What Country? 414 Folcroft St Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ 3 Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Soap Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burt Eperson Unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo E. Peterson, Jr./Son 2938 Cornwall St Dundalk, MD 21222 other t 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any Injury or c 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory, Inc 4/2/07 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 frederick Rd Baltimore, MD 21228 Todd Dring 23a. Part1. Enter the disease, or complior lons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖺 No 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Malnutrition 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No Hydrocephalus this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation Injury ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064624 March 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sandeep Sharma 9000 Franklin Square Dr Baltimore, MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			T = For State Registrar		State of	Maryla	nd / Depa	artmer <i>rtificat</i>					()	007	Ι Ω Ι. Ω Ι
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Vital	Physician: The law this certificate has b al director, page 2 s	Be	25. Was case referred to me examiner?	-	Hospital:				Othor			(Check only o	ne)		
00	Physr this eral di	<u>ا ب</u>	1 ☐ Yes 2 No 27. Manner of Death		28a. Date of		ER/Outpatient 28b. Time of		^	4 LI Nur		ie 5 ☐ Resid 8d. Describe h			(y)
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6			29a. Certifier 1 Cert	fying Phy	ysician: To the b	est of my kno	owledge, death	occurred :	at the time	e, date and	d place, a	nd due to the o	ause(s) and	manner as s	tated.
(v)	the hin 24 the F	Medical			and manne	r stated.						u at the time, t	ate and plac	e, and due t	o the cause(s)
	viti v	2	29b. Signature and title of cer	tifier		1. 1		29c	License		~		9d. Date sig		
		-	, K. O		1	M, D,			7 20	0656	0		MARCI	128,	700/
	12		30. Name and address of per							, pm	Ω	~		0 0	2.7.6
	Stat	e	31. Date filed (Month, Day, Y	ear)	32. Reg	jistrar's Sign	ature	CA IC	AU	nE t	DAL	MOE	E M	<u>u</u> 21	1224
	Registra	ar	APR	3 2	007	istrar's Sign	J. 40								

			State of Manuand / De	partment of Health and M								
			. FOI	Certificate of Death		2007 10482						
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death						
	Physici /Medic		Doris Virginia Peach		March	28,2007 3:55 PM						
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
	Euporol		Salisbury Rehab a Nursing 5. Social Security Number 6. Sex 7. Age (In yrs. last with	ay) If Under 1 Year If Under 24 Hrs.	Date of Birth	9. Birthplace (State or Foreign						
	Funeral Director		214-14-5356 1□M XDF 86 Yrs	Months Days Hours Min.	(Month, Day, Y Sep. 8,	1920 Maryland						
	pug ≱		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	r Location		10d. Inside City Limits						
	Maryia Isho	jo	MD Wicomico	Tyaskin		1 ☐ Yes 2 ☐ No						
	or 28a	lrec	10e. Street and Number	10f. Zip Code	10g	). Citizen of What Country?						
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or itema 23a or 28a-f show event, the Medical Evaninar must be notified at	Funeral Director	23049 Capitola Road	21865		United States						
	er deg	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 (2No	<ol> <li>Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.						
20	urs aft al', or	by	3 Xwidowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White						
215-0036	72 ho	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ocedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)	ing 16	b. Kind of Business/Industry						
7	within ne. than "	ld m	Flamentary/Secondary (0-12)   College (1-40/ 5+)	e. DO NOT use retired) Receptionist		Hardware Store						
V	filled Hygi other ent, L	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma							
ומחם	uld be Aental rked c	To B	Oliver Blair	Kathl	een Cora	n						
lar)	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked of any injury or other traumatic ev once.	Ė	19a. Informant's Name/Relationship ( <i>Type, Print</i> ) Barbara Peach - Daughter in Law 23	ailing Address <i>(Street and Number or Rura</i> 049 Capitola Rd T	Naskin.	City or Town, State, Zip Code)						
ຄຸ ≥	1 and Health em 27 ther t		20a Method of Disposition 20b. Place of Di	sposition (Name of		c. Location - City or Town, State						
ě	ages ant of tr: If it y or o	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)  20c. Location - City or Cemetery, crematory or other place)  20c. Location - City or Cemetery, crematory or other place)  20c. Location - City or Cemetery, crematory or other place)  20c. Location - City or Cemetery, crematory or other place)										
Saltimore	mit. F partme portar y injur	(	21. Signifue of Funeral Service Licentee	22. Name and Address of Facility Am	brose Fu	neral Home, Inc.						
מ	8 3 3 8	/	Carme Com 1904	1328 Sulphur Spring	Rd., Arl	outus, MD 21227						
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death						
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or a 1 consequence of):	s Disease -	lud 57	ng*						
	Examiner											
	B .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying									
) .	executed in and ial-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C									
5	bur bur	calE	d									
00	sici <b>an:</b> The law requires that the death certificate be certificate has been signed by the attending physicia rector, page 2 should be detached for use as the bur											
X D D	ath cer Itendir or use	Physician/Med		3 Ectopic pregnancy		23d. Date of delivery  Month Day Year						
5	he dearthe a	yslc	1 Yes 2 No 9 Unknown 4 Pregnant at time of death	5 Other (specify)								
ŗ	The law requires that the ate has been signed by tho page 2 should be detached.	by Ph	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?						
cords	aquires en sign	ed b			1 ☐ Yes	2 No 3 Probably 4 Unknown						
ပ် မ	law re as be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
	: The cate h . page	Con			performe 1 ☐ Yes 2	d? death? No 1 Yes 2 No						
Vila	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	/	(Check only one)	ce 6 □Other (Specify)						
5	g Phy er this neral d	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time	e of 28c. Injury at	28d. Describe how							
100	endin eath. or; Aft he fur	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No								
	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)						
_	spital lours a neral I		29a. Certifier Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place,	and due to the caus	se(s) and manner as stated.						
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director; After this certific completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.		ed at the time, date	and place, and due to the cause(s)						
	Withi To 1	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)						
			- c salling	15 D252/9		3-28-07						
	3		30. Name and address of person who complete cause of death (Item 23a) (Type Charles D. Steaman Mt.	Vernan Rd 7	rinces	s Anne, MDal853						
	Sta	te	31. Date filed (Month, Day, Year) 42. Registrar's Signature	1:	.,	-/						
	Registr	ar	APR 0 3 2007 See 15	gode								

LUKE BURTON PERSAUD Baltimore, Maryland 21215-0036

		For State	Pleas	e Type or Pri AMEND State of M	nt in I TEM/ arylar				. <b>Ens</b> i /4/07 4ealth <i>Death</i>		II Copie: Iental Hy			·.	
<i>h</i> . =	9	Registrar  1. Decedent's Nam	e (First, Middle,	Last)		Cei	TIIIC	ale of	Deam		2. Date of D		200	3. Time of De	O C
Physici /Medi		Luke B	urton I	Persaud							MARC	Da 4 2		- Paul 19 1 1 1 1 1	<i>P</i> M
Examir	er	4a. Facility Name (/		give street and number)	-h . a	. (	4b. Ci	ty, Town, o	or Location			40	. County of D	eath	
Funeral Director		5. Social Security N			e ( <i>In yr</i> s. N /	last birthday) Yrs.	If Und	der 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D 3 - 29	irth la <i>y, Ye<u>a</u>r,</i>	9. 1	Birthplace (State or Fo Country) ryland	oreigi
w w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City L	imite
Mary I-f sho fied at	tor	MD	Baltin	nore Co.		ssex								1 □ Yes 2	
n with the 23a or 28a st be noti	Funeral Director	10e. Street and Nu		nn Road				Zip Code 2122	1				izen of What	Country?	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  The TS1 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Marr 3 □ Widowed	ied 2□ Married 4□ Divorced	12. Was Decedent Armed Forces? 1	1			cedent of I pecify Cub 2 XNo			ecify Yes or N Rican, etc.)	0-	14. Race - Ai Black, W Specify:		
"natu	Completed by	(Spec	15. Decedent's cify only highest	Education grade completed)		16a. Deced	lent's U	sual Occup work done	pation during mos d)	t of work	ing	16b. K	ind of Busine	ss/Industry	
giene, ir than the M	ф	Elementary/Seco	ndary (0-12)	College (1-4or	5+)	,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	N/A	<b>G</b> )				A\N		
tal Hyg d othe event,	Be	17. Father's Name	(First, Middle, La	ist)					18. Mothe	er's Name	e (First, Middle	e, Maider	Surname)		
d Men marke	မ	Burton 19a. Informant's Na				10b Mailir	a Addre				Khan_	lumber, City or Town, State, Zip Code)			
alth an 27 Is ir trau			· · · · ·	ıd - Fathe	er						Essex				
Department of Health a Important: If Item 27 Is any Injury or other trau		20a. Method of Disp		☐Removal from State	20b. F	Place of Dispo					Date			or Town, State	
tment tant: I		4 ☐ Donation	5 Other (Spe	cify)	0a	klawn	Cer	nete	ry /	4-2-	2007	Bal	timor	e, MD	
Department of Important; If any Injury or once.		21. Signature of Fu	ineral Service I	ensee		1 /	. Name	and Addre	ess of Facili	<sup>ty</sup> Kac	zorow	ski	Funer	al Home, 4D 21222	,
hysician /Medical prial-transit	al Examiner	Immediate Cause (disease or condition resulting in death)  Sequentially list conif any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	nditions, imediate anying injury	a. Due to (or as b. Due to (or as c. Due to (or as	a conseq	uence of):	RE	MAI	URIT!	1				1 minute	5
een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	d.  23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3		pregnanc specify)	у				23d. Date of o	delivery Day Year	r
De de	by	Part II. Other signif	ficant conditions	s contributing to death b	ut not res	ulting in the ur	nderlying	j cause giv	en in Part I					to the cause of death	
2 sl	Completed	<u> </u>									24a. Was auto perf 1 Yes		prior t death		ilable e of
this certificate	Be C	25. Was case reference examiner? 1 ☐ Yes 2 【 ■		Hospital:		ER/Outpatien		OCA Oth	er:		(Check only				
th. : After this e funeral dii	tion: To	27. Manner of Death  1 Natural  2 Accident		28a. Date of Inju (Month, Date)	ırv	28b. Time of Injury	t 3□   M	28c. Injur Wor	4 🗀 140		me 5 ☐ Res 28d. Describe			pecify)	
within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		ury - At ho c. (Specif	ome, farm, stre	et, fact	ory, office	-		28f. Location City or To			Rural Route Number,	
n 24 hour ne Funeri oletely filli	Medical (	29a. Certifier (Check only one)	1 CertifyIng 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examina	wledge, death ition and/or inv	occurre estigati	ed at the ti	me, date ar opinion, dea	nd płace, ath occuri	and due to the red at the time	cause(s , date an	and manner place, and d	as stated. lue to the cause(s)	
within 24 hours a To the Funeral completely filled	Σ	29b. Signature and	the certifier					9c. Licens	inn	51				onth, Day, Year)	
		30. Name and addr	ess of person wh	o completed cause of d	eath (Item	n 23a) (Tvpe. I	Print)	1/00	629	77		Mr	HC4	21224	,
		JOSCI	TEA QU	Uroz 49	40	EASTE	RN	AVEN	JUE 1	BAL	Timon	E	mo :	21224	
Sta Registr		31. Date filed (Mon		32. Registr	ar's Signa	ture	رع							,	

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 12-46PM OUISE /Medical MARCH 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES HOSPITAL BALTIMORE BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG, 17, 190 9. Birthplace (State or Foreign Country) VIRGINIA **Funeral** 223-32-8402 1 ☐ M 2 🕱 F Months Days Hours Director Usual Residence of Decedent 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MARYLAND 10e. Street and Number Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced Be Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6THGRADE 4UNDR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARLES ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIHORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Porial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septice Licensee BALTO, MD. 2121 AVE, 234 Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o'Dieart failure. List only one cause on each line. ediate Cause (Final Onset and Death **Physician** PNEUMONIA lease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 1 ☐ Yes 2 No 9 Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Faiku 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? sate has autopsy certificate 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: this Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \underline{\square}$ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

P.O. Box 68760, Records, Division or Vital

Medical

State Registrar

31. Date filed (Month, P

K. Vishnu Dcepita

DEEPIKA

29b. Signature and title of certifier

EVURI 900 S. CATON Ave, BALTIMORE, MD - 21229 istrar's Signature

MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

P 20998

29d. Date signed (Month, Day, Year)

MARCH 31, 2007

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

'natural", or

r than "

if Health and Mental Hygiene.
Item 27 Is marked other than other traumatic event, the N

permit. Pages
Department of I
Important: If it
any injury or o
once. ō

Directo

Funeral

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Completed

Be

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Examine

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

atten for u signed by the a d be detached f certificate has birector, page 2 s or Attending Physician: I Director: d in by the within 24 hours a

To the Funeral I

completely filled filled

edica		d CORONHRY HRIERY DISERSE						
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	23d. Date of delivery  Month Day Year					
7	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?					
g g	RENAL INSUFFIC	IENCY	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
completed by	ATRIAL ARRHYTH	MIA	24a. Was an autopsy performed?  1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No					
še	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)					
0	1 ☐ Yes 2 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 Other (Specify)					
tion:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	8d. Describe how injury occurred					
Certifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)					
edical	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 ★ Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)					
Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	Kichard	L. Lythicum D 31826	4-2-07					

DHMH 17 Rev 1/2001

State

Registrar

Hospital

ro the h

7601 OSLER DRIVE, TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD L

31. Date filed (Month, Day, Year)

APR 0 3 2007

INTHICUM, M.D.

Registrar's Signature

M.D.

State of Maryland / Department of Health and Mental Hygiene ? For State Registra Certificate of Death Rea. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Didina Valica Popa 11:15 p.nM April 1, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore Baltimore City** Future Care Charles Village 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Romania 5. Social Security Number **Funeral** 1 M 200 F December 11, 1946 Yrs 242-21-8467 60 Director Usuel Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Texas El Paso El Paso 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 5 79936 itsme 23a 1682 Robert Wynn Dr. Funeral deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Peges 1 end 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. snt: if item 27 ie marked other then "neturei; or its 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 250 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced Ith and Mental Hygiene.
27 le marked other then "netur treumetic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Education Elementary/Secondary (0-12) Colfege (1-4or 5+) School Teacher 4+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Domnica Unknown Girgore Valica ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6905 Timber Creek Ct. Clarksville, Maryland 21029 Son Mr. Christian Popa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H important: if its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 04/03/2007 Svkesville, Marvland 4 Donation 5 Other (Specify) All County Cremation Services, Inc. 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure). List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Finaf nuta vata **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Onaemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit 80 sond Due to (or as a consequence of) Box 68760, ettending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 2 100 1 Yes Hospital or Attending Physicien: director 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 No deeth. i Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 Homicide 24 hours a 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie avo 31464 0 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 821 N. EUTAN ST Sout 308 BALTIMOLE MD 2120 HASHMIMD, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** M 1:30 A 2007 28 Richard Baldwin Penman March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Timonium 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral X** M 2 □ F Sept. 30 1937 Director 69 MD 212-36-4293 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medica Examiner must be notified at 1 ☐ Yes 2√2 No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 1 Athenry Ct. Apt. 101 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) n/a Meat Cutter Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental James Andrew Penman Justine Baldwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau Athenry Ct. Apt. 101, Timonium, MD 21093 Martha Joeann Penman/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

Signature of Euror of Avice 1 Avice Metro Crematory 3/31/07 Catonsville, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Lowell M. Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER METASTATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transil Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) Records, P.O. the a 9□Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1□ Yes **Division or Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**No ٩ 1 ☐ Yes 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death within 24 hours after death.

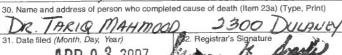
To the Funeral Director: After completely filled in by the funera Certification: (Month, Day Year) or Attending Injury 1 Natural 2 Accident 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

B

State Registrar

TARIQ MAHMOOD 31. Date filed (Month, Day, Year) APR 0 3 2007

29b. Signature and title of certifie



2300 Duraney Vaccey Ro, Timonium, MD 21093

29d. Date signed (Month, Day, Year)

29c. License number

		•	For State Registrar	State of Maryland / [	Department of Health and Certificate of Death	d Mental Hygiei Reg.	6001	0488
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	D. Rascot	L, Sr.	2. Date of Death Month HARCH 2	Day Year	Time of Death
	Examir Funeral Director		5. Social Security Number 6. Sex	navitan Hospi 7. Age (In yrs. last bir	4b. City, Town, or Location of D  Authority  If Under 1 Year If Under 24 I  Months Days Hours M	Hrs. 8. Date of Birth	4c. County of Death  N/A  9. Birthplace Country)	(State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow		3012 3, 1	10d. l	nside City Limits
	or 28s-f	Director	MD N/A  10e. Street and Number		Baltimone 101. Zip Code		Citizen of What Country?	
336	gas 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-f show or other treumatic event, the Medical Examinar must be invitited at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces?/ 1 □ Yes 2 □ No If Yes, Give Year or Dates:	2123		14. Race - American Ir Black, White, etc. Specify: Ame	ndian, i'(our not cour
21215-0036	d within 72 hou glene. ir then "nature I've Medicel E	Completed	15. Decedent's Educat (Specify only highest grade of		Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b	. Kind of Business/Industr	vetrus
R MSC aryland:	should be filed nd Mental Hygio marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Joseph R	2ascoe		Name (First, Middle, Maio Blanch	2 Winsto	7)
ARRV Baltimore, Mar	permit. Pages 1 and 2 should be filed within Deportment of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other treumatic event, Ital Magnee.		19a. Informant's Name/Relationship (Type,  Tyree Lo. Rasce  20a. Method of Disposition  1 □/Burial 2 □ Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)	e/Paughter 20b. Place o	Mailing Address (Street and Number of Seabury Roof Disposition (Name of try, crematory or other place)  Course Course 4	Date 200	Location - City or Town,	State
L A / Baltin	permit. P Depertme importar eny injur		21. Signature of Funeral Solvice Lice oc		22. Name and Address of Facility  1407   F. C. 10-  5/26 Below	se Funeral R al	Service, P.P.	9. 1206-5NS
8760,**	Physician /Medical Examiner  buly sicien and strength to bright the prival-transit strength to be executed as the prival-transit strength to be executed as the prival transit strength transit strength to be executed as the prival transit strength transit strength transit strength transit strength to be executed as the prival transit strength trans	dical Examiner	shock, or heart failure. List only one disease or condition resulting in death)  Sequentially list conditions, if any, leading to mine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence	utk			arval Between set and Death
Box 6	- O 0	Physician/Me	IF FEMALE: 23c. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day	/ Year
ords, P.O	w requires that the back is been signed by should be detact	Ď	Part II. Other significant conditions contri	buting to death but not resulting i	n the underlying cause given in Part I.		co use contribute to the ca	
Division of Vital Records,	sicien: The law re certificate has be irector, page 2 sho	Completed				24a. Was an autopsy performed		
V.	Physicien: this certifics ral director.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1 Inpatient 2 ER/O	Othor	Death (Check only one)  ng Home 5  Residence	e 6 □Other (Specify)	
sion of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		27. Manne J Death 1 latural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	Time of injury M 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how		
Divis	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by t	Certification:		28e. Place of Injury - At home, fa building, etc. (Specify)		City or Town, S		
	• Hosp 24 ho • Fune	Medical			e, death occurred at the time, date and a nd/or investigation, in my opinion, death			
	To th within To th compl	Me	29b. Signature and title of certifier	MV	29c. License number	29d.	Date signed (Month, Day	Year)
	H		30. Name and address of person who compared to the state of the state	pleted cause of death (Item 23a)	(Type, Print) IT NIA	PASSEA	THKCH +1	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	LOCH KHVEN S	LVD SHLII	HUNE, MI	21239
1	Regist	ar	APR 0 3 2007	personal St. A.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** March 31, 2007 1:00 PM Doris Mae Rinaldi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2XF 89 219-01-0412 1917 West Virginia 18, Director Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 3/31/07 1 ☐ Yes 2√ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21206 USA 5625 North Lane Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items dical Examiner mu Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by 3 X Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phillip S. Booth Dora Bryan ို 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Rinaldi/Son 5625 North Lane Baltimore, MD 21206 : If item? 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc | 4/2/07 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 /all 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vascular disease Immediate Cause (Final disease or condition resulting in death) pmplicaturs **Physician** LAVS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?
1☐Yes 2☐No
9☐Unknown Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Inknown Demina Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy nerform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 🛏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 31 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Tower M 21204

State Registrar 31. Date filed (Month, Day, Year) APR 0 3 2007 32 Registrar's Signature

Rinaldi, Doris

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Raymond Romai		I- For State Registrar	of Maryland / L	Department o Certificate o		a Mental Hyg	Reg	2001	7 10490
Physicia Medical Examir		1. Decedent's Name (First, Middle, Las	t)	R	MAN		Date of Death Month [ March 23, 2	Day Year 2007	3 Time of Death 2100 hrs
		4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, or			4c. County of Death	
Funeral	=	University Hospital  5. Social Security Number 6. Social Security Numb	7 Age /I	n yrs. last birthday)	Baltimore If Under 1 Year	r If Under 24Hrs. 8	R Date of Birth	(MM/DD/YYYY) 9. Birt	2 hplace (State or
Funeral Director	Į	215-52-0151 12	M 2 F	58 Y	Months Days	House Min	SEP1. A	Foreig	
any .	-	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loca					10d. Inside City Limits
rland -f shov	ğ	Md. NI	A	BALTI	MORE 10f. Zip Code		Lio	0.1.	1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 2907 W. BEL	LIENERE A.	IE APTITI	10f. Zip Code	21215	109	Citizen of What Cour	,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Eve Armed Forces?			panic Origin? ( Speci , Mexican, Puerto Ric		14. Race - Americ White, etc.	can Indian, Black,
after dea	by Fur	`	1 Yes 2 If Yes, Give Year or Dates:		Yes 2 X No	specify:		Specify: 81	rck.
hours a	ed be	15. Decedent's Education (Specify of	nly highest grade comple			ion (Give kind of work DO NOT use retired)		6b. Kind of Business/Ir	ndustry
036 thin 72 hours after ne. than "natural", thin al Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	9BOREL	_		INC	45124
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Nehnal Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	Col	17. Father's Name (First, Middle, Last)	,	1		18.Mother's Name (Fi		omane)	
212 buld be Menta mark	ωĮ	19a. Informant's Name/Relationship (T					al Route Numbe	er, City or Town, State,	
MD nd 2 sho alth and m 27 is	`_	OPERINE FISHER	1 51510	e 2901	W. BEL.	VECLERE 1	we #1	Balton, 1	1d 2/2/5 Town, State
Ore, es l an of Hea If iter	ļ	20a. Method of Disposition  1  Burial 2 Cremation 3	Removal from State	crematory or o	ther place)	/ ///			
Baltimore, permit Pages I ar Department of Her Important: If ite Imjury or other tr	-	4 Donation 5 Other Specify 21. Signature of Funeral Service Licer	see	LAKKISON	FOREST VI	of Facility	10+ 0	OWENGS A.	11115, Mol.
Balt permit Depart Import injury	Ì	Sun Doly	morte	) 8	700 Edm	eridson 2	tre. B	Balfor ma	.21223
Physician /Medical	4	23d. Part I. Enter the disease, or comp failure. List only one cause on ea		death. Do not enter	the mode of dying,	such as cardiac or re	spiratory arrest	t, shock, or heart	Approximate Interval Between Onset and Death
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executed an and al - transit		d		· 				···	
60, ate be ex hysician e burial	Medical	X UNPENDED	#23a,27,perl	Œ,g867 <u>,</u> 5/1	0/07 TT			22d Data of delivery	
5876 ertificate ding phy		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 F	etal death 3 [	Ectopic pregnancy	1	23d. Date of delivery  Month D	ay Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/	1 Yes 2 No 9 Unknown	9 Unknown	e or death 5 [ ] (	Other (Specify)			Y	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	by P	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause g	jiven in Part I.		acco use contribute to t	
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tal R	BeC	25 Was case referred to medical examiner?	logalital:			of Death (Check only			
of Vit Physic er this	2	1 ✓ Yes 2 No 27. Manner of Death		2 ER/Outpatier		Other Nursing H		esidence 6 Other	
Sion o	tion:	1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)			res 2 No		, ,	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the sa ther death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification	2 Accident Investigati 3 Suicide 6 Could not	be 28e. Place of Injury	r - At home, farm, str	eet, factory, office b	ouilding, etc. 28	f. Location (Stror Town, Sta	eet and Number or Ruite)	al Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		4 Homicide determine 29a. Certifier 1 Certifying Physic	(Specify) ian: To the best of my kr	nowledge, death occ	urred at the time, da	ate and place, and du	e to the cause(	s) and manner as state	ed.
To the Hos within 24 h To the Fur completely	Medical		On the basis of examination				e time, date an	nd place, and due to the	e cause(s)
othing	Ž	29b. Signature and title of certifier	1 1/		29c. Licens		1	29d Date signed (Mor March 24, 2007	th, Day, Year)
1/4 1/2	-	30. Name and address of person who	completed cause of deat	(Item 23a)	2			, ===,	
1.4		Theodore M King Ir ME	Assistant Med	lical Examiner	111 Penn Str	reet, Baltimore, I	MD 21201		
Sta Regist	ate	31. Date filed (Month, Day, Year)  APR 0 3 20	32. Registrar's S	Signature	ede				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARCH 5:30 pM 2007 Dante J. Rapisarda, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Baltimore Center Towson 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) July 18, 1923 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Maryland 83 216-12-7193 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other tranmatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Perry Hall Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21128 u. S. A. 1 B Brook Farm Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 8th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Rapisarda Vincencina Spampinato မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health (Item 27 i 3 C Brook Farm Ct., Perry Hall, Maryland 21128 Frank Rapisarda (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/04/2007 Baltimore, Maryland Parkwood Cemtery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PULMONARY EMBOLI disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform 1∐ Yes 2 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. the

Registrar DHMH 17 Rev 1/2001

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State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KHOSROW TABASSI.

APR 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 767

7601

29c. License number

D 46356

OSLER DRIVE. TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND

			For State Registrar		State o	of Maryla	ind / Dep <i>Ce</i>	artmer				lental Hy	/giene (. Reg. No.	2007		0492
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	Funeral	2	5. Social Security Number		x ⊐м 2A⊐F		s. last birthday	/ If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D March	rth ay, Year)	9. Bi	country)	State or Foreign
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Ę.	ding Physician: The h. h. Atler this certificete h funeral director, page	iuo!	27. Manner of Death 1 ☑ Natural 5 ☐	Pending		of Injury oth, Day Year)	28b. Time Injury		28c. Injun Work			28d. Describe	how injury	occurred		
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Division of Vital Records,	or A after Direction by	Certification:	4 Homicide	determined	build	ling, etc. (Spe	cify)	treet, racto	у, опісе				wn, State)		nurai nout	e wamber,
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	he Ho he Fu pletel	Medical	one)		iner: On the b	ner stated.	nation and/or	nvestigatio	n, in my o	pinion, dea	ith occurr	red at the time	, date and	place, and du	e to the ca	ause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARCH FREIDA RICHARD 30 2007 3:15 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 4700 COYLE ROAD APT. # 201 OWINGS MILLS If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1□M 2₩F Yrs. 76 WASHINGTON, DC 219-32-6701 09/06/1930 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD BALTIMORE OWINGS MILLS 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4700 COYLE ROAD APT. #201 21117 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **TEACHER EDUCATION** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEVINE SOPHIA SCHREIBER ဥ HYMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4700 COYLE ROAD APT. #201 - OWINGS MILLS, MD 21117 JACK RICHARD / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KNESSETH ISRAEL CONG. 04/01/2007 ANNAPOLIS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mast Ce 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician VICOSOUS; 2 WEEKS Due to (or as a consequence of): /Medical Examiner Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine rsician and Hospital or Attending Physician: The law requires that the death certificate be executed Spinal Stenosi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician by Physician/Medical the the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No nours after death.
neral Director; A
filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated.

within 24 hours al

To the Funeral C

completely filled i

State Registrar

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120556n, M.D. 31. Date filed (Month, Day, Year) APR 0 3 2007

29b. Signature and title of certifier

(rossroads . Registrar's Signature

Kmm.o.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1)42561

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2007 March 27, **Physician** Hazel Elizabeth Riley 2:07 Рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Hospice of Baltimore Gilchrist Ctr. Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Apr. 24, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 1 □ M 2 □ F Months 181-01-4133 1914 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland anent of Health and Mental Hygiene. The state of Herns 23a or 28a-f show ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD Freeland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21053 USA 1312 Walker Road 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Yes, Give Specify. Specify: þ If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced Il Hygiene. other than "natura /ent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Eiementary/Secondary (0-12) 11 Hairdresser Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Weir Carrie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trau Maureen Rissmiller / dtr. 1312 Walker Road; Freeland, MD 21053 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 □ Cremation 3 □ Removal from State 3/31/07 Harrington, DE Hollywood Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Immediate Cause (Final **Physician** Noke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician as by Physician/Medical as attending properties IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 pronths?

1 Yes 2 Who
9 Unknown Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 2 10 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, director Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPLA ို 1 ☐ Yes 2× No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1/2 Natural 5 Pending Injury 1 Yes 2 No investigation death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records. P.O. Box 68760. within 24 hours after death

To the Funeral Director:
completely filled in by the To the Hospital

> State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only

29b. Signature and ottle of certifier

31. Date filed (Month, Day, Year) APR 0 3 2007



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

ORIGINIAL

29d. Date signed (Month, Day, Year)

2007

march 27

Charles St Rower, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-1 per me, g865,03/29/07dhb

Reg. No. - Reg. Reg. No. - 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 29, 2007 12:00 A Michael Thomas Schaech January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Manor Care - West Road Towson 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Maryland Director 214-92-1017 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State show Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No Funeral Director Towson Baltimdre Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 111 West Road 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Body Shop Tech. Auto Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel J. Schaech, Jr. Angela Connelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Camberley Circle T-3, Towson, Maryland Angela Schaech (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 02/01/2007 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD. Dulanev Vallev Mem. Gardens 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Libensee 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Anoxic enertalogath disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner aspiration The law requires that the death certificate be executed MON APPROVED BY Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2000 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 No subject driver in a motorcycle investigation 08/25/1985 | Unknown<sup>M</sup> Accident To the Funeral Director: 28f. Location (Street and Number or Rural R **accident** City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Roadway Easton, MD 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier Tol 031885 K1 702 nia- - 0001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kloun Rm 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 9 2007 Registrar

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To the within To the compl	Medical	and manner stated.	and/or	29c. Licens		red at the time, date		(Month, Day, Year)		
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		- Mayne The Krall	am 23a)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
1	-	30. Name and address of person who completed cause of death (Ite Margarita Korell MD. Assistant Medical Exam		111 Penn Street, B	altimore, l	MD 21201				
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** М Hallie Stevens 2007 /Medical March 8:45 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Eastpoint Nursing & Rehab Baltimore Dundalk Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 💢 F Yrs. 230-20-1583 May 20, 1924 Virginia Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 N No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1913 Codd Avenue United States Funeral 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√€ No Specify: White 2 3 ☐ Widowed XXDivorced Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 years Retail Sales Sales/J. S. Penney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William S. Montgomery ဂ <u>Virginia Ryan</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ellinger (Sister) Codd Avenue Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Willtop Serv. Corp. 4/3/2007 Towson, Maryland 21. Signature of Funeral Service Liturasee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Nhknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of gause of autonsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

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**Funeral** 

Director

28a-f show

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Hygiene.

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Physician /Medical

Examiner

3altimore, Maryland 21215-0036

funeral director, Certification: To After t ours after death.
neral Director: A
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within 2 State

29b. Signature and title of certifier

6 ☐ Could not be

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

eath (Item 23a) (Type, Print)
2 Mg. & ICUI- Place Dundalk MD 21222 e of death (Item 23a) (Type, Print)

39. Registrar's Signature 31. Date filed (Month, Day, Year)

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Registrar

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	Sta	-	31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	and a	p						
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:22 an Physician Lucille R. Small Mar 31 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and num Examiner Baltimore N/A 3irthplac Country) MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT 19, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🂢 F 214-24-4406 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10c. City, Town or Location "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 □Yes 2 ▼ No Director Baltimore Catonsville MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21228 **USA** 262 Blakeney Rd Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify: White Specify. Completed by 3X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator/Clerk Phone Company 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Shover William Emmerich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau Bonnie Small/Daughter 262 Blakeney Rd Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 4/2/07 Baltimore, MD Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 21. Signature of Funeral Service Licensee Todd Dring Call 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician year /Medical pulmonary disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 TYes After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours are. To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

Hospital or Attending Physician: the

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

2001

o completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Baltimore, MD, 21229

			1 - State Registrar	e of Maryland /	•	tment of F		Re	g. No.	10500		
	Physici	an	Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Year	3. Time of Death		
	/Medic	al	Veranta Sewel  4a. Facility Name (If not institution, give street and	Location of Death	Mar	30 2007 4c. County of Death	04:05AM					
	Examin	er	Mercy Medical Cert		4	Belti			N/A			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last be		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	1	place (State or Foreign		
	Director		213-72-7567 1□ № ※2	₹ 50	Yrs.	Months Days	Hours Min.		,1957 Mar			
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									
	f aho	5	Maryland N/A Baltimore						1 ☑ Yes 2 ☐ No			
	the 1	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?		
	h with		4112 Belle Avenue			2121	5		USA			
۵	should be filed within 72 hours after death with the Maryland of Menial Hygiene. marked other than "natural", or itema 23a or 28a-f ahow marke avant, the Madical Examiner must be motified at	Funerai	11. Marital Status 12. Was Arme	Decedent Ever in U.S. d Forces? 'es 2 1 No		s Decedent of H es, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Bla	etc.		
Maryland 21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year	or Dates:				1.				
7	in 72 i	Completed	15. Decedent's Education (Specify only highest grade comple	ted)	(Give kin	nt's Usual Occup nd of work done of NOT use retired	during most of worki	ng	6b. Kind of Business/N			
212	yiene.	шо	Elementary/Secondary (0-12) College 2 Yea	ge (1-4or 5+) ars C1	aims	Exami	ner		dministra			
9	be filed Ital Hyg Id other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	aiden Sumame)			
<u>X</u>	should to nd Ment marked umatic a	P.	Harold H. Davis	-			Sonja S					
ă Z	2 2 2 2		19a. Informant's Name/Relationship (Type, Print) Sonja Smith/ Mother						City or Town, State, Zi imore, Ms			
a T	s 1 and I Health Itam 27 other tr		20a. Method of Disposition	20b. Place of	of Dispositi	on (Name of lory or other place		ate 2	0c. Location - City or T			
Ê	Peges nent of nnt: If It nry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify) /			rial P		) / W	oodlawn,	Maryland		
Baltimore,	permit. Peges Department of Important: If It any injury or o		21. Signature of Funeral Service Ucomiee						arris Fur altimore,	neral Home		
		4	23a. Part. Enter the disease, or complications the	nat caused the death. Do					1	Approximate Interval Between		
	Pnysician /Medical	1		Chastatic to (or as a consequence		ost Co	ncer			Onset and Death		
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Einter Union lying Cause (Disease or injury that imitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
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58750,	icate be executed physiclen and s the burial-transit	edicai	d									
			IF FEMALE:	N. 20 N. 20 N.								
ROX	leath certifi ettending   I for use as	ian/	23b. Was decedent pregnant in the past 12 months?			23d. Date of delivery  Month Day Year						
o.	at the de by the stached	ysic		regnant at time of death nknown	200	ther (specify)						
7	The law requires that the death certil te has been signed by the ettending page 2 should be detached for use a	by Physician/M	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
ğ	w require been sig should b							1 🗆 Yes	s 2 No 3 Pro	bably 4 \( Unknown		
Vital Records,	law reas be	Completed		24a. Was an autopsy	autopsy prior to completion of cause of							
		Соп				perform 1 Yes 2	2 No					
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ō	Phys rthis raldii	7	27. Manner Death 28a. D	4   Nuising Ho	ing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred							
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DIVISION OF	or Atta after des Diracto in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Bural Route Number or Rural Route Numbe									
_	To the Hospital or Attending Physiclen: within 42 hours after death. To the Funeral Director. After this certified completely filled in by the funeral director.											
	thin 2 thin 2 tha mplet	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date							Date signed (Month, Day, Year)		
•	F 3 F 8		Klengel Dans	1106	110							
	7		30. Name and address of person who completed	cause of death (Item 23a)	(Type, Pri	nt)	, •	,	lar, 30, 2007 21202			
	U		Chenell Donadee MD	cause of death (Item 23a)	Place	Balti	more, M	, MD 21202				
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signature	for the							